

9367

CERTIFICATE OF DEATH

09352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 Mo 15 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, d. STREET ADDRESS 6670 Palmer Rd., S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Lovie Coleman Ball			4. DATE OF DEATH Month Day Year August 1 19 58		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1893		9. AGE (In years last birthday) yrs. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Windsor, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Williams			14. MOTHER'S MAIDEN NAME Rachel Williams		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Alex V. Warren, 330 A Street, N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary infarcts 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction of the spleen					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 17 , 19 58 to Aug 1 , 19 58 that I last saw the deceased alive on Aug 1 , 19 58 , and that death occurred at 10:06 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE William H. Rosson		ADDRESS (Street, city or town, state) 5304 Annapolis Road		DATE SIGNED Bladensburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-6-58	22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.		ADDRESS 3001 12th St., N.E.		24a. REC'D BY REGISTRAR AUG 7 '58	24b. REGISTRAR'S SIGNATURE W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

Registration No.

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

PERMANENT CAUSE

INTERMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

LOCATION OF THE DEATH

DATE

TIME

INITIALS

DATE

9368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Barnett Last Barnett		4. DATE OF DEATH Month August Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Mar. 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hall		14. MOTHER'S MAIDEN NAME Margaret Power	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Barnett Nutwell Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Carcinoma of Breast c metastasis to lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) To lungs (c) To lungs		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-6 , 19 58 , to 8-29 , 19 58 that I last saw the deceased alive on 8-29 , 19 58 , and that death occurred at 6:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick B Hartsock M.D.		DATE SIGNED 8-29-58	
PHYSICIAN'S NAME (Type) Dr. Frederick B Hartsock, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Reese		24. REC'D BY REGISTRAR SEP 9 '58	
ADDRESS Annapolis Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1918

100-111

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES EARL RAY		35		M		W		1903		MEMPHIS		TENNESSEE		TENNESSEE		TENNESSEE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
APRIL 4, 1968		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		SHOOTING		SUICIDE		CIVILIAN		HIGH SCHOOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH CERTIFICATE OFFICER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHIEF OF POLICE		SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED IN DEPT. OF HEALTH
BALTIMORE, MARYLAND
APRIL 11, 1968
100-111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9369

CERTIFICATE OF DEATH

Reg. Dist. No.

09353

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville,							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 1 62k3 4kst Pl.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle F Last Barnhart				4. DATE OF DEATH Month August 23, Year 19 58									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-94		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent				10b. KIND OF BUSINESS OR INDUSTRY Metro. Life Ins.		11. BIRTHPLACE (State or foreign country) Denton, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John S. Barnhart				14. MOTHER'S MAIDEN NAME Clara Peters									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go. or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Frances F. Barnhart, 6213--41st Pl.				Address: Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Sennhoter Occlus. in Left Cor. Artery DUE TO Arterio sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 19 48, to 8-23, 19 58, that I last saw the deceased alive on 8-23, 19 58, and that death occurred at 10-20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R. Adoff Fleischer M.D. 5832 Queens Chapel Rd PHYSICIAN'S NAME (Type) Dr. Ronald Fleischer 1049 Hoston Ave 8/23/58													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/26/1958		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.				22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.						24a. REC'D BY REGISTRAR DATE AUG 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneave					

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE		MD		USA		NORTH AMERICA	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		1865		BALTIMORE		MD		USA		NORTH AMERICA	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		OTHER	
JAMES H. HARRIS		MARY J. HARRIS		ELIZABETH HARRIS		JOHN HARRIS		HIGH SCHOOL		METHODIST		DEMOCRAT		NONE		NONE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
1910		J. H. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
BALTIMORE
MAY 10 1910

9370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverley Md.		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier 16			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4112 33 rd. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle N. Last Beach Jr.				4. DATE OF DEATH Month August Day 6 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/05		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney				10b. KIND OF BUSINESS OR INDUSTRY Professional Law		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME CLARENCE N. BEACH				14. MOTHER'S MAIDEN NAME Mary Ella Lewellyn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Lucille Beach		Address 4112 33 St. Mt. Rainier	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) broncho pneumonia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hepatic decompensation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2 , 19 58 , to August 6 , 19 58 , that I last saw the deceased alive on August 6 , 19 58 , and that death occurred at 4:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3108 Rhode Island DATE SIGNED 8/6/58 ACTUAL SIGNATURE Sam L. Leventy M.D. Mt Rainier PHYSICIAN'S NAME (Type) Dr. Levitsky Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/58		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc. Md				ADDRESS Mt. Rainier		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
				24b. REGISTRAR'S SIGNATURE Alb. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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9429

CERTIFICATE OF DEATH

09354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Cedars Rest Home		d. STREET ADDRESS 14530 Powder Mill Road,.	
3. NAME OF DECEASED (Type or print) First Olive Middle Bendz Last Beall		4. DATE OF DEATH Month August Day 3 Year 19 58-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 9, 1868
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Waldmer Bendz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Samuel Beall		Address Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Dis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO 15 yrs (c) Senile DUE TO 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gen'l Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs 10 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 58-6/1 to 58-8/3 , that I last saw the deceased alive on 58-8/3 , and that death occurred at 58-8/3 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Beltsville, Md. DATE SIGNED 5/3/58			
ACTUAL SIGNATURE J. M. Warren M.D. Laurel			
PHYSICIAN'S NAME (Type) J. M. Warren Laurel, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/58	
22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Beltsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gorch's Sons ADDRESS 4737 Balto. Ave Hyatts Md			
24a. REC'D BY REGISTRAR DATE AUG 6 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1912		Boston, Mass.	
Cause of Death		Disease		Symptoms		Duration		Time of Day		Month and Year	
Heart Disease		Myocardial Infarction		Chest Pain		2 Weeks		10:00 AM		January 1912	
Occupation		Education		Marital Status		Previous Illnesses		Signature of Physician		Signature of Registrar	
Carpenter		High School		Married		None		[Signature]		[Signature]	
Place of Burial		Name of Burial Place		Date of Burial		Time of Burial		Signature of Minister		Signature of Registrar	
Catholics		St. Mary's Church		1912		10:00 AM		[Signature]		[Signature]	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 This certificate is to be filled out by the physician or other qualified person who has attended the deceased.
 It is to be filed in the office of the Registrar of Vital Statistics, Boston, and a copy is to be sent to the local health officer.
 The date of death must be given in full, and the cause of death must be stated in full, and the place of death must be given in full.
 The signature of the physician or other qualified person must be given in full, and the signature of the Registrar must be given in full.
 The signature of the Minister must be given in full, and the signature of the Registrar must be given in full.

9371

CERTIFICATE OF DEATH

Reg. Dist. No.

09356

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 11 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospt.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Everett Jackson Beavers				4. DATE OF DEATH Month August Day 12 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-81	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Everett John Beavers Address 625 57th Ave Capital Heights Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelo Nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2 , 19 58 to August 12 , 19 58 at I last saw the deceased alive on August 12 , 19 58 , and that death occurred at 8:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles C. Hageage, M.D. 3308 PERRY ST. MT. RAINIER, MARYLAND				ADDRESS (Street, city or town, state) 3308 Perry St, Mt. Rainier, Md.			
DATE SIGNED 8/13/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C.				24a. REC'D BY REGISTRAR DATE AUG 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0211

PLACE OF DEATH HOME		DECEASED NAME JOHN DOE		SEX MALE	
AGE 45		OCCUPATION LABORER		DATE OF BIRTH JAN 15 1875	
PLACE OF BIRTH IOWA		MARITAL STATUS SINGLE		DATE OF DEATH AUG 10 1918	
CAUSE OF DEATH TYPHOID FEVER		MEDICAL HISTORY NONE		TIME OF DEATH 10:30 AM	
PLACE OF INTERMENT CEMETERY		NAME OF FUNERAL HOME NONE		SIGNATURE OF DECEASED NONE	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF MINISTER W. B. JONES		SIGNATURE OF WITNESSES A. B. C. D. E.	

18

MAITLAND STATE DEPARTMENT OF HEALTH - BATHORE, 18

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH - BATHORE, 18

MAITLAND STATE DEPARTMENT OF HEALTH - BATHORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09358

9372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 41			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 206 Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ralph Middle E Last Benton				4. DATE OF DEATH Month August Day 17 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1898		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Race Tracks		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arnie Benton				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 194-22-8089		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Lung (Rt) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/2 19 58 to 8/17/58 , 19 58 , that I last saw the deceased alive on 8/18 , 19 58 , and that death occurred at 5:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. M. Warren M.D.							
PHYSICIAN'S NAME (Type) John M. Warren, M.D., 305 Prince George St., Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Aug 20, 1958		St Marys Cem.		Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Carrigan, Laurel, Md.				24a. REC'D BY REGISTRAR DATE AUG 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

A black and white photograph of a book cover. The cover is light-colored and appears to be made of a textured material like cloth or paper. On the left side, there are two large, dark, irregular shapes that look like holes or significant stains. The top shape is roughly triangular with a jagged edge, and the bottom shape is more elongated and also has a jagged edge. The background of the cover is mostly blank, with some faint, illegible text visible in the upper right corner.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09359

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

99

I

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Scotland	
c. LENGTH OF STAY IN 1b Died natural		d. STREET ADDRESS 14317-Brookes Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul (Bernard) Black		4. DATE OF DEATH August 8 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1911
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Insurance		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.-C	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Katie Lee Black, daughter of the deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 874.0 DUE TO acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Curiosis of Liver, myocardosis		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wrench thrown overboard of boat	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Aug 8 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Scotland P.s. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-58	
22c. NAME OF CEMETERY OR CREMATORY Washington Natl.		22d. LOCATION (City, town, or county) Scotland Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamberlain, Inc. 517-11 St. S.E.		24a. REC'D BY REGISTRAR AUG 12 1958	
		24b. REGISTRAR'S SIGNATURE Arthur L. Prunty	

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

HEALTH DATE

1900

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1916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9366

CERTIFICATE OF DEATH

Reg. Dist. No.

09360

1. PLACE OF DEATH a. COUNTY <u>Sakoma Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 3/4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Sakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7224 Minter Place</u>				d. STREET ADDRESS <u>7224 Minter Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE CRAWFORD BLAKER</u>				4. DATE OF DEATH Month Day Year <u>August 31 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1872</u>	
9. AGE <u>86</u> years last birthday		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>7224 Minter Pl. Sak. Pk Md</u>		17. INFORMANT Address <u>Mrs. Ruth Stiles, 7224 Minter Pl. Sak. Pk Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>many years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>August 31, 1958</u> , that I last saw the deceased alive on <u>8/31</u> , 1958, and that death occurred at <u>8:20 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash DC</u> DATE SIGNED <u>8/31/58</u> ACTUAL SIGNATURE <u>James R Coleman MD</u> M.D. PHYSICIAN'S NAME (Type) <u>James R Coleman MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 5, 1958</u>		<u>Old Cedar Hill Cemetery</u>		<u>Philadelphia Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Arthur Walters, 254 Carroll St NW Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

9354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9534 Rhode Island Avenue,.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.	
d. STREET ADDRESS 9534 Rhode Island Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MURRAY Middle GEORGE Last BONHAM		4. DATE OF DEATH Month August Day 7 Year 1958-19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elias Bonham		14. MOTHER'S MAIDEN NAME Emma Whitenight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Gertrude Bonham		Address College Park, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung and trachea 1620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of carotid artery DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13 , 19 58 , to 8-7 , 19 58 , that I last saw the deceased alive on 8-7 , 19 58 , and that death occurred at 6:00 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Via A. J. O. A. M.		DATE SIGNED 4314 GALLATIN ST.	
PHYSICIAN'S NAME (Type) TILL BERGEMANN		HYATTSTVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/9/58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE AUG 11 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Time of Death		Manner of Death		Occupation	
Residence		Birthplace		Date of Birth	
Marital Status		Education		Religion	
Previous Illnesses		Previous Injuries		Previous Operations	
Attending Physician		Medical Examiner		Coroner	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
Date of Certificate		Place of Issuance		Official Seal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09361

CERTIFICATE OF DEATH

Reg. Dist. No.

9374

1. PLACE OF DEATH o. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Va b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Junction, Maryland d. STREET ADDRESS 83 x - 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter H Bouis		4. DATE OF DEATH Month Day Year August 17 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1879
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY US Navy Yard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Bouis		14. MOTHER'S MAIDEN NAME Achsah White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Artero-Septal Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arterio-Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/23/58 , 19 58 , to 8/17/58 , 19 58 , that I last saw the deceased alive on 8/17/58 , 19 58 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE B. P. Warren M.D.			
PHYSICIAN'S NAME (Type) Bryan P. Warren, M.D., 305 Prince George St., Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Aug 19 1958	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Long Hill Cem.		Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE He Witt Donaldson		24a. REC'D BY REGISTRAR DATE AUG 22 '58	
ADDRESS Laurel Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Fries	

03503

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>		<p>3. AGE [Age]</p>	
<p>4. DATE OF DEATH [Date]</p>		<p>5. TIME OF DEATH [Time]</p>		<p>6. PLACE OF DEATH [Place]</p>	
<p>7. CAUSE OF DEATH [Cause]</p>		<p>8. MANNER OF DEATH [Manner]</p>		<p>9. SIGNATURE OF DECEASED [Signature]</p>	
<p>10. SIGNATURE OF WITNESSES [Signatures]</p>		<p>11. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>13. SIGNATURE OF CLERK [Signature]</p>		<p>14. SIGNATURE OF JURY [Signatures]</p>		<p>15. SIGNATURE OF JUDGE [Signature]</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

Reg. Dist. No.

09362

9430

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Accokeek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charlotte Gertrude Bowers</u>				4. DATE OF DEATH Month Day Year <u>Aug 3 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Edwin Blandford, Accokeek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Annular Constriction of Stomach 3 months</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete pyloric obstruction 2 weeks</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1947</u> , to <u>8-3 1958</u> , that I last saw the deceased alive on <u>8-3 1958</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>David S. Gordon, M.D.</u> <u>5731 23rd Parkway, SE 8-3-58</u> PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u> <u>Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Huntt Funeral Home, Waldorf, Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED Prince George Asoket</p>		<p>AGE 10</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH Jan 12 1891</p>		<p>PLACE OF DEATH Annapolis</p>	
<p>CAUSE OF DEATH Cholera</p>		<p>PLACE OF BIRTH Annapolis</p>	
<p>DATE OF BIRTH Jan 12 1891</p>		<p>PLACE OF BIRTH Annapolis</p>	
<p>NAME OF DECEASED Prince George Asoket</p>		<p>AGE 10</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH Jan 12 1891</p>		<p>PLACE OF DEATH Annapolis</p>	
<p>CAUSE OF DEATH Cholera</p>		<p>PLACE OF BIRTH Annapolis</p>	
<p>DATE OF BIRTH Jan 12 1891</p>		<p>PLACE OF BIRTH Annapolis</p>	

9375

CERTIFICATE OF DEATH

Reg. Dist. No. 09363

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>709 Chillum Road</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>LANHAM</u> Last <u>BOYKIN</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 3, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Private Law Practice</u>		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT EMMET BOYKIN</u>	
14. MOTHER'S MAIDEN NAME <u>GERTRUDE LANHAM</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-05-3703</u>		17. INFORMANT <u>DOROTHY BOYKIN</u> Address <u>2800 Quebec St. N.W. WASHINGTON, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Esophageal Varices</u> 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the Liver</u> DUE TO (c) <u>Chronic Alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb.</u> 19 <u>58</u> , to <u>Aug. 9</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 8</u> 19 <u>58</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D.				ADDRESS (Street, city or town, state) <u>1806 Fox St, Hyattsville, MD</u>			
DATE SIGNED <u>8/9/58</u>							
PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 12 '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Val Funeral Home</u>				ADDRESS <u>2224 W. Ave. N.W., Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kravitz</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF CITY CLERK		22. SIGNATURE OF TOWNSHIP CLERK	
23. SIGNATURE OF VILLAGE CLERK		24. SIGNATURE OF POST OFFICE CLERK	
25. SIGNATURE OF SCHOOL CLERK		26. SIGNATURE OF CHURCH CLERK	
27. SIGNATURE OF SYNAGOGUE CLERK		28. SIGNATURE OF MOSQUE CLERK	
29. SIGNATURE OF TEMPLE CLERK		30. SIGNATURE OF OTHER CLERK	



RECEIVED
MAY 1918
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9376

CERTIFICATE OF DEATH

09364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier d. STREET ADDRESS 3706 37th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank E. Boyle		4. DATE OF DEATH Month Day Year August 1 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-82
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Insurance	
10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Ada Boyle Address 3706 37th St., Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinsons Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 19 58 to August 1, 19 58 that I last saw the deceased alive on August 1, 19 58 , and that death occurred at 1:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Benjamin L. Miller, M.D. 3824-34 St Mt Rainier 2 Aug 58			
ACTUAL SIGNATURE Benjamin L. Miller, M.D.			
PHYSICIAN'S NAME (Type) DR B. S. Miller			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		8/4/58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Fort Lincoln		Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Valley's Funeral Home Inc.		DATE AUG 6 '58	
ADDRESS Mt Rainier Md		24b. REGISTRAR'S SIGNATURE Al. Smith	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Signature of Physician	
Signature of Registrar		Date of Registration		Place of Registration	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

9377

CERTIFICATE OF DEATH

Reg. Dist. No.

09365

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital				d. STREET ADDRESS 4708 Indian Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANK Middle WILLARD Last BOYLE				4. DATE OF DEATH Month August Day 24th , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5th, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer Retired U.S. Gov't				10b. KIND OF BUSINESS OR INDUSTRY Maine		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Willard Boyle				14. MOTHER'S MAIDEN NAME Emma Crosby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. 220-05-2715			
17. INFORMANT Amelia C. Boyle, 4708 Indian Lane,				Address College Park, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Systolic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Systolic DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 5201 Baltimore Ave.,				20g. (County) Hyattsville, Md.		20h. (State) 8/25/1958	
21. I certify that I attended the deceased from 8-21 to 8-25 , 19 58 , that I last saw the deceased alive on 8-21 , 19 58 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Hays				DATE SIGNED 8/25/1958			
PHYSICIAN'S NAME (Type) Leonard Hays				ADDRESS 5201 Baltimore Ave., Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27/1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE AUG 27 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

09366

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Box #8 Branch Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry Fenton</u> First <u>BRADLEY</u> Middle <u>BRADLEY</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 18, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>	
13. FATHER'S NAME <u>Henry BRADLEY</u>		14. MOTHER'S MAIDEN NAME <u>Augusta E. SHERMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5-77-26-2835</u>	
17. INFORMANT <u>Mrs. Mary E. Bradley</u>		Address <u>Clinton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia, Secondary to above</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1955</u> to <u>August 6, 1958</u> , that I last saw the deceased alive on <u>August 6, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2412 Minnesota Avenue S.E.</u>	
PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON, M.D.</u>		<u>Washington 20, D.C.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-8-58</u>	<u>Washington, National</u>	<u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co.</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruze</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM W. GILBERT		AGE 63		SEX M		RACE W		DATE OF BIRTH 1878		PLACE OF BIRTH BALTIMORE, MD	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		DISEASE OR INJURY CORONARY ARTERY DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME	
DATE OF DEATH JAN 10 1941		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		NAME OF PHYSICIAN DR. J. H. GILBERT		NAME OF FUNERAL HOME GILBERT & SONS		NAME OF MINISTER REV. J. H. GILBERT	
NAME OF NEXT OF KIN WILLIAM W. GILBERT		NAME OF FUNERAL HOME GILBERT & SONS		NAME OF MINISTER REV. J. H. GILBERT		NAME OF BURIAL PLACE GILBERT & SONS		NAME OF CEMETERY GILBERT & SONS		NAME OF INTERMENT GILBERT & SONS	
NAME OF DECEASED WILLIAM W. GILBERT		AGE 63		SEX M		RACE W		DATE OF BIRTH 1878		PLACE OF BIRTH BALTIMORE, MD	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		DISEASE OR INJURY CORONARY ARTERY DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME	
DATE OF DEATH JAN 10 1941		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		NAME OF PHYSICIAN DR. J. H. GILBERT		NAME OF FUNERAL HOME GILBERT & SONS		NAME OF MINISTER REV. J. H. GILBERT	
NAME OF NEXT OF KIN WILLIAM W. GILBERT		NAME OF FUNERAL HOME GILBERT & SONS		NAME OF MINISTER REV. J. H. GILBERT		NAME OF BURIAL PLACE GILBERT & SONS		NAME OF CEMETERY GILBERT & SONS		NAME OF INTERMENT GILBERT & SONS	

9432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box .272. Route # 2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper. Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle W Last Brown		4. DATE OF DEATH Month August. Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18. 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Brown		14. MOTHER'S MAIDEN NAME Caroline. V. Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	
17. INFORMANT Lawrence, R. Cobb		Address Box. 272. Route #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 527.1 Emphysema IMMEDIATE CAUSE (a) DUE TO Conjunctive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 year 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 19 58 , to Aug 13, 19 58 , that I last saw the deceased alive on Aug 13, 19 58 , and that death occurred at 1:10 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Sasser		DATE SIGNED 8-13-58	
PHYSICIAN'S NAME (Type) James E. Sasser M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 16. 1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel.	22d. LOCATION (City, town, or county) (State) Upper, Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lees. Sons Co.		ADDRESS 300. 4th st N.E.	
24a. REC'D BY REGISTRAR DATE AUG 18 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Princess George	
Sex		Male	
Date of Birth		Oct. 18, 1937	
Place of Birth		England	
Residence at Date of Death		Cambridge, Mass.	
Cause of Death		No	
Place of Death		Cambridge, Mass.	
Date of Death		Aug. 13, 1948	
Signature of Physician		Dr. J. W. H. H. H.	
Signature of Registrar		J. W. H. H. H.	
Signature of Deceased		Princess George	
Signature of Next of Kin		J. W. H. H. H.	
Signature of Burial Officer		J. W. H. H. H.	
Signature of Minister of the Gospel		J. W. H. H. H.	
Signature of Undertaker		J. W. H. H. H.	
Signature of Coroner		J. W. H. H. H.	
Signature of Medical Examiner		J. W. H. H. H.	
Signature of Pathologist		J. W. H. H. H.	
Signature of Anatomist		J. W. H. H. H.	
Signature of Surgeon		J. W. H. H. H.	
Signature of Dentist		J. W. H. H. H.	
Signature of Pharmacist		J. W. H. H. H.	
Signature of Nurse		J. W. H. H. H.	
Signature of Hospital		J. W. H. H. H.	
Signature of City		J. W. H. H. H.	
Signature of State		J. W. H. H. H.	
Signature of Country		J. W. H. H. H.	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 17, Film G-233 9/22/58.cac.

09368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH PRINCE GEORGES GENERAL HOSPITAL COUNTY PRINCE GEORGES MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CHEVERLY, MARYLAND HOSPITAL OR INSTITUTION OR STREET ADDRESS PRINCE GEORGES GENERAL HOSPITAL		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY PRINCE GEORGES CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NORTH FORESTVILLE, MARYLAND STREET ADDRESS 3306 WINTER GREEN AVENUE, N. FORESTVILLE	
3. NAME OF DECEASED (Type or Print) STELLA A. BUTLER		4. DATE OF DEATH (Month) (Day) (Year) AUGUST 30th 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 8/11/1880
9. AGE last birthday 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER	
11. BIRTHPLACE (State or foreign country) EAST BROOK, MAINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HARDISON		14. MOTHER'S MAIDEN NAME IDA HARDISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS MRS. BEAVER FILLAH (DAUGHTER) 3306 WINTER GREEN AVENUE, N. FORESTVILLE MD.			
18. MEDICAL CERTIFICATION Charles 443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage ANTECEDENT CAUSE(S) DUE TO Hypertensive Heart Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from August 29, 1958, to August 30, 1958, that I last saw the deceased alive on August 30, 1958, and that death occurred at 12:00 PM from the causes and on the date stated above. SIGNATURE Benjamin S. Pearson M.D. ADDRESS 7711-MASON STREET, DISTRICT HEIGHTS, MD. 8/30/58 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/31/1958	
24. REC'D BY REGISTRAR DATE SEP 2 '58		REGISTRAR'S SIGNATURE Arthur S. Pearson	
25. FUNERAL DIRECTOR'S SIGNATURE Wash. D.C. MARTIN W. HYSOING CO. 1300 N. STREET, N.W.		ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9433

CERTIFICATE OF DEATH

Reg. Dist. No. 09369

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S. E. Wash. D. C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Temple Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5215 Fisher Rd.		d. STREET ADDRESS 5215 Fisher Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID First Middle H. Butz Last		4. DATE OF DEATH Aug. 16 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 July 1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer Ret'd.		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. BIRTHPLACE (State or foreign country) U.S. A.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME David Butz		14. MOTHER'S MAIDEN NAME Susan Hazen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Julia A. Butz 5215 Fisher Rd. S. E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Acute Pulmonary Edema DUE TO (b) Chronic Congestive Heart Failure DUE TO (c) Generalized Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 yr. 30 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1, 1955, to 8/16, 1958, that I last saw the deceased alive on 8/12/1958, and that death occurred at 5:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Lynn M.D. 5241 St. Barnabas Rd. S.E.		DATE SIGNED 8/16/58	
PHYSICIAN'S NAME (Type) JOHN T. LYNN		5241 ST. BARNABAS RD. S.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 18 A ug '58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) Suitland (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funera 1 Home 4 & Mass. Av. N. E.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. France	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX M		3. AGE 45	
4. DATE OF DEATH JAN 10 1911		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. DISEASE OR INJURY CORONARY ARTERY DISEASE		9. PREVIOUS ILLNESS NONE	
10. SIGNATURE OF PHYSICIAN J. H. HARRIS		11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF DECEASED J. H. HARRIS	
13. SIGNATURE OF REGISTRAR J. H. HARRIS		14. SIGNATURE OF CLERK J. H. HARRIS		15. SIGNATURE OF JURY J. H. HARRIS	
16. SIGNATURE OF JURY J. H. HARRIS		17. SIGNATURE OF JURY J. H. HARRIS		18. SIGNATURE OF JURY J. H. HARRIS	
19. SIGNATURE OF JURY J. H. HARRIS		20. SIGNATURE OF JURY J. H. HARRIS		21. SIGNATURE OF JURY J. H. HARRIS	
22. SIGNATURE OF JURY J. H. HARRIS		23. SIGNATURE OF JURY J. H. HARRIS		24. SIGNATURE OF JURY J. H. HARRIS	
25. SIGNATURE OF JURY J. H. HARRIS		26. SIGNATURE OF JURY J. H. HARRIS		27. SIGNATURE OF JURY J. H. HARRIS	
28. SIGNATURE OF JURY J. H. HARRIS		29. SIGNATURE OF JURY J. H. HARRIS		30. SIGNATURE OF JURY J. H. HARRIS	
31. SIGNATURE OF JURY J. H. HARRIS		32. SIGNATURE OF JURY J. H. HARRIS		33. SIGNATURE OF JURY J. H. HARRIS	
34. SIGNATURE OF JURY J. H. HARRIS		35. SIGNATURE OF JURY J. H. HARRIS		36. SIGNATURE OF JURY J. H. HARRIS	
37. SIGNATURE OF JURY J. H. HARRIS		38. SIGNATURE OF JURY J. H. HARRIS		39. SIGNATURE OF JURY J. H. HARRIS	
40. SIGNATURE OF JURY J. H. HARRIS		41. SIGNATURE OF JURY J. H. HARRIS		42. SIGNATURE OF JURY J. H. HARRIS	
43. SIGNATURE OF JURY J. H. HARRIS		44. SIGNATURE OF JURY J. H. HARRIS		45. SIGNATURE OF JURY J. H. HARRIS	
46. SIGNATURE OF JURY J. H. HARRIS		47. SIGNATURE OF JURY J. H. HARRIS		48. SIGNATURE OF JURY J. H. HARRIS	
49. SIGNATURE OF JURY J. H. HARRIS		50. SIGNATURE OF JURY J. H. HARRIS		51. SIGNATURE OF JURY J. H. HARRIS	
52. SIGNATURE OF JURY J. H. HARRIS		53. SIGNATURE OF JURY J. H. HARRIS		54. SIGNATURE OF JURY J. H. HARRIS	
55. SIGNATURE OF JURY J. H. HARRIS		56. SIGNATURE OF JURY J. H. HARRIS		57. SIGNATURE OF JURY J. H. HARRIS	
58. SIGNATURE OF JURY J. H. HARRIS		59. SIGNATURE OF JURY J. H. HARRIS		60. SIGNATURE OF JURY J. H. HARRIS	
61. SIGNATURE OF JURY J. H. HARRIS		62. SIGNATURE OF JURY J. H. HARRIS		63. SIGNATURE OF JURY J. H. HARRIS	
64. SIGNATURE OF JURY J. H. HARRIS		65. SIGNATURE OF JURY J. H. HARRIS		66. SIGNATURE OF JURY J. H. HARRIS	
67. SIGNATURE OF JURY J. H. HARRIS		68. SIGNATURE OF JURY J. H. HARRIS		69. SIGNATURE OF JURY J. H. HARRIS	
70. SIGNATURE OF JURY J. H. HARRIS		71. SIGNATURE OF JURY J. H. HARRIS		72. SIGNATURE OF JURY J. H. HARRIS	
73. SIGNATURE OF JURY J. H. HARRIS		74. SIGNATURE OF JURY J. H. HARRIS		75. SIGNATURE OF JURY J. H. HARRIS	
76. SIGNATURE OF JURY J. H. HARRIS		77. SIGNATURE OF JURY J. H. HARRIS		78. SIGNATURE OF JURY J. H. HARRIS	
79. SIGNATURE OF JURY J. H. HARRIS		80. SIGNATURE OF JURY J. H. HARRIS		81. SIGNATURE OF JURY J. H. HARRIS	
82. SIGNATURE OF JURY J. H. HARRIS		83. SIGNATURE OF JURY J. H. HARRIS		84. SIGNATURE OF JURY J. H. HARRIS	
85. SIGNATURE OF JURY J. H. HARRIS		86. SIGNATURE OF JURY J. H. HARRIS		87. SIGNATURE OF JURY J. H. HARRIS	
88. SIGNATURE OF JURY J. H. HARRIS		89. SIGNATURE OF JURY J. H. HARRIS		90. SIGNATURE OF JURY J. H. HARRIS	
91. SIGNATURE OF JURY J. H. HARRIS		92. SIGNATURE OF JURY J. H. HARRIS		93. SIGNATURE OF JURY J. H. HARRIS	
94. SIGNATURE OF JURY J. H. HARRIS		95. SIGNATURE OF JURY J. H. HARRIS		96. SIGNATURE OF JURY J. H. HARRIS	
97. SIGNATURE OF JURY J. H. HARRIS		98. SIGNATURE OF JURY J. H. HARRIS		99. SIGNATURE OF JURY J. H. HARRIS	
100. SIGNATURE OF JURY J. H. HARRIS		101. SIGNATURE OF JURY J. H. HARRIS		102. SIGNATURE OF JURY J. H. HARRIS	

FOR STATE
HEALTH DEPT.

9379

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Barnaby</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>5511 Second St</u>	
3. NAME OF DECEASED (Type or print) <u>John Thomas Clarke</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1892</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Live Stock Dealer</u>		9b. AGE (In years last birthday) <u>66</u> yrs. <u>8</u> mos. <u>0</u> days <u>0</u> hrs. <u>0</u> min.	
10. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>		13. FATHER'S NAME <u>Charles Edward Clark</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine's Alexander</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI</u>	
16. SOCIAL SECURITY NO. <u>578-48-4125</u>		17. INFORMANT <u>John Thomas Clark</u> Address <u>2602 Gutter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>23 Aug -58</u>		22b. DATE THEREOF <u>23 Aug -58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem -</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 44 Main Ave NE DC</u>		24a. REC'D BY REGISTRAR <u>Aug 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9356

CERTIFICATE OF DEATH

Reg. Dist. No.

09371

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington</u> b. COUNTY <u>Dist of Col</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 640. K St NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				d. STREET ADDRESS <u>Hyattsville, Md 41X-3</u>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>F.</u> Middle <u>CONNERY</u> Last				4. DATE OF DEATH <u>August 7</u> 19 <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTH PLACE (State or foreign country) <u>Gallatin, Mont</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>James Donahue</u>				14. MOTHER'S MAIDEN NAME <u>Deale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Ruth L Connery</u>				Address <u>640. K St NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Congestive Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 12 1958</u> to <u>Aug 7 1958</u> , that I last saw the deceased alive on <u>Aug 6 1958</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William T. Saccardi</u> M.D.				ADDRESS (Street, city or town, state) <u>1150 Conn Ave, WASH. D.C</u>			
DATE SIGNED <u>8/8/58</u>							
PHYSICIAN'S NAME (Type) <u>WILLIAM T. SACCARDI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 11-1958</u>		<u>St. Agnes Cemetery</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J F Loostello</u>				ADDRESS <u>1722 North Capitol</u>			
24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>					

10037

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

10037

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10-15-1918</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. PERIOD OF ILLNESS <i>2 weeks</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
RECEIVED JANUARY 10 1919
BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09372

9380

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lakeland-College Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 4903 Navahoe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Henry First Thomas Middle Conway Last			4. DATE OF DEATH Month August Day 29 Year 1958		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-99	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.			13. FATHER'S NAME Frank Conway		
14. MOTHER'S MAIDEN NAME Nellie Thomas			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Ralph E. Conway; 4901 Navahoe St., College Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO (b) Paraplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Tumor of spine					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) College Park, Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 3, 58		22c. NAME OF CEMETERY OR CREMATORY Carver	
22d. LOCATION (City, town, or county) Maryland		22e. REGISTRAR'S SIGNATURE Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis		ADDRESS 1432 10th St. N.W.		24a. REC'D BY REGISTRAR DATE SEP 5 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

QUESTIONS

Name of Deceased		John T. Conway	
Age		30	
Sex		Male	
Race		Caucasian	
Birth Date		1903	
Birth Place		Maryland	
Usual Residence		1903 Conway Street, College Park, Md.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date		August 30, 1933	

THE OFFICE OF THE MEDICAL EXAMINER IS A DIVISION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE DUTY OF THE EXAMINER TO DETERMINE THE CAUSE AND MANNER OF DEATH IN ALL CASES OF SUDDEN DEATH, AND TO REPORT THE RESULTS OF HIS EXAMINATION TO THE STATE DEPARTMENT OF HEALTH. THE EXAMINER IS NOT A JUDGE OF FACTS, BUT A JUDGE OF MEDICAL SCIENCE. HIS REPORT IS A STATEMENT OF HIS OPINION, BASED ON THE EVIDENCE BEFORE HIM. IT IS NOT A VERDICT, AND IT IS NOT BINDING ON THE COURTS. THE COURTS ARE THE JUDGES OF FACTS, AND THEY MAY REJECT THE EXAMINER'S REPORT IF THEY SEE FIT. THE EXAMINER'S REPORT IS A STATEMENT OF HIS OPINION, BASED ON THE EVIDENCE BEFORE HIM. IT IS NOT A VERDICT, AND IT IS NOT BINDING ON THE COURTS. THE COURTS ARE THE JUDGES OF FACTS, AND THEY MAY REJECT THE EXAMINER'S REPORT IF THEY SEE FIT.

9381

CERTIFICATE OF DEATH

Reg. Dist. No.

09373

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASH.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lebanon Mem. Hosp.</u>				d. STREET ADDRESS <u>1244 Emerson St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence A. Coppage</u>				4. DATE OF DEATH Month Day Year <u>AUG 9 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 JULY 1908</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cromwell, VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Thomas Coppage</u>			
14. MOTHER'S MAIDEN NAME <u>MARY Helfin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWII</u>			
16. SOCIAL SECURITY NO. <u>223-14 4328</u>				17. INFORMANT Address <u>LONA Coppage 1244 Emerson St. N.E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>56</u> to <u>Aug 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>58</u> , and that death occurred at <u>2:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Chester Brady</u> M.D.				ADDRESS (Street, city or town, state) <u>35 N. Y. Ave. N. W.</u>			
DATE SIGNED <u>9/9/58</u>				PHYSICIAN'S NAME (Type) <u>J. Chester Brady</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13 Aug '58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>ARB Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 4 Maryland Ave</u> ADDRESS				24a. REC'D BY REGISTRAR <u>12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Krueger</u>	

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9382

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G233 8/28/58 gpi

CERTIFICATE OF DEATH

Reg. Dist. No.

09374

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>28 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Cornwell</u> Last <u>Cornwell</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-93</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emory Hollingsford</u>		14. MOTHER'S MAIDEN NAME <u>Anna Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Hospital</u>	
17. INFORMANT <u>Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.R. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 24, 1957</u> , to <u>August 20, 1958</u> , that I last saw the deceased alive on <u>Aug 20, 1958</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William Brainin</u>		DATE SIGNED <u>8/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Detonator Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collier</u>		ADDRESS <u>3821-14th St. N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Frank</u>	

1 **#B**
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9383

Reg. Dist. No. 09375

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 15 Bryant Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John F Dalton			4. DATE OF DEATH Month August Day 19 Year 1958		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1902		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		10b. KIND OF BUSINESS OR INDUSTRY Gov't Pr. Office		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Dalton			14. MOTHER'S MAIDEN NAME Rachael Boyd		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Dora Dalton 1900 F. St. N.W. Washington, D.C. Div. Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 19, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. Burial		22b. DATE THEREOF 8/21/58		22c. LOCATION (City, town, or county) (State) Albany New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 22 '58 DATE	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10460

9434

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. Penna. b. COUNTY Alleghany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegheny Pittsburgh 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB		d. STREET ADDRESS 411 Fannel 1725 D St., S.E., Wash, D.C.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Infant Davis		4. DATE OF DEATH Month Day Year August 21 19 58	
5. SEX Female	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21, 1958
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Davis		14. MOTHER'S MAIDEN NAME Florence R. Bonner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Father, 1725 D St., S.E., Wash, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1239 to 1255	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1250 hrs to 19, to 1255 hrs, 19, that I last saw the deceased alive on 21 August, 1958, and that death occurred at 1255 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews 21 August 1958			
ACTUAL SIGNATURE Douglas E. Pierce M.D.			
PHYSICIAN'S NAME (Type) DOUGLAS E. PIERCE, Capt, USAF (MD)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8/27/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins 4804 Kalamazoo Rd		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050171XVO

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1920</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. DISEASE OR INJURY <i>Coronary Artery Disease</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>11. SIGNATURE OF REGISTRAR <i>W. H. Jones</i></p>		<p>12. SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i></p>	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER OF THE DISTRICT IN WHICH THE DECEASED RESIDES.

DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

9384

CERTIFICATE OF DEATH

Reg. Dist. No.

09376

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS P.O. Box 337, Church Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Arthur Davis				4. DATE OF DEATH Month Day Year August 21 19 58			
5. SEX Mael		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1903	
9. AGE (In years lost birthday) yrs. 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Greenwood Knolls, Scotland Co., N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Davis				14. MOTHER'S MAIDEN NAME Fannie Hallaah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 239-16 8548		17. INFORMANT Henry H. Davis Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 DUE TO Multifocal Cerebral Spleen + Red Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subacute Bacterial Endocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bladensburg, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from Aug 21, 1958 , to Aug 21, 1958 , that I last saw the deceased alive on Aug 21, 1958 , and that death occurred at 10:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Rosson MD				ADDRESS (Street, city or town, state) 5304 Annapolis Road			
PHYSICIAN'S NAME (Type) William D. Rosson MD				DATE SIGNED Aug 25 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				ADDRESS Mt Rainier Md		24a. REC'D BY REGISTRAR AUG 25 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. House							

MEDICAL CERTIFICATION

2

77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: *William B. Brown*

2. Sex: *Male*

3. Age: *65*

4. Date of birth: *Jan 15, 1880*

5. Date of death: *Dec 10, 1945*

6. Place of death: *Home*

7. Cause of death: *Heart disease*

8. Signature of physician: *Dr. J. H. Smith*

9. Signature of registrar: *John Doe*

10. Signature of informant: *John Doe*

11. Date of registration: *Dec 15, 1945*

12. Place of registration: *Baltimore, Md.*

13. Name of registrar: *John Doe*

14. Name of informant: *John Doe*

15. Name of physician: *Dr. J. H. Smith*

16. Name of funeral home: *John Doe*

17. Name of cemetery: *John Doe*

18. Name of burial place: *John Doe*

19. Name of burial place: *John Doe*

20. Name of burial place: *John Doe*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9385

Reg. Dist. No. 9377

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>824 - 51st Avenue</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u> d. STREET ADDRESS <u>824 - 51st Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John Raymond Davis</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			4. DATE OF DEATH <u>Aug 13 1958</u> Month Day Year 8. DATE OF BIRTH <u>Aug 30 1931</u> 9. AGE (In years) <u>26</u> yrs. If UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) <u>Dispatcher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Topical</u> 11. BIRTH PLACE (State or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Robert Davis</u> 14. MOTHER'S MAIDEN NAME <u>Mabel Getty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>57940-934</u> 17. INFORMANT <u>Charles B. Davis, son of #2</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hanging</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self from bed post</u>			
20c. TIME OF INJURY Month, Day, Year <u>Aug 8-13 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Capital Heights P.G. Co.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 13, 1958</u> DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington, National</u>	
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co. Washington, D. C.</u> ADDRESS			
24a. REC'D BY REGISTRAR <u>AUG 15 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

228



CERTIFICATE OF DEATH

9355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4720 Nantucket Road,.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jose Middle C Last De Mello				4. DATE OF DEATH Month August Day 9 Year 1958- 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 23, 1887	
9. AGE (In years to birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Azores	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Gurtrude Moniz				Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO General arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) undetermined (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 5, 1957 to July 9, 1958 , that I last saw the deceased alive on July 5, 1958 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Malin M.D.				ADDRESS (Street, city or town, state) Baltimore, Md DATE SIGNED Aug 9, 1958			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR AUG 12 1958				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "Jan 15, 1900"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
DATE OF DEATH [Faint text, possibly "Jan 20, 1945"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "Mrs. J. Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "C. D. White"]		SIGNATURE OF CLERK [Faint text, possibly "E. F. Green"]	
ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Baltimore, Md."]		ADDRESS OF NEXT OF KIN [Faint text, possibly "456 Oak St, Baltimore, Md."]		ADDRESS OF REGISTRAR [Faint text, possibly "789 Pine St, Baltimore, Md."]	
DATE OF INTERMENT [Faint text, possibly "Jan 22, 1945"]		PLACE OF INTERMENT [Faint text, possibly "Greenwood Cemetery"]		NAME OF FUNERAL HOME [Faint text, possibly "The Baltimore Funeral Home"]	
NAME OF FUNERAL HOME [Faint text, possibly "The Baltimore Funeral Home"]		NAME OF FUNERAL HOME [Faint text, possibly "The Baltimore Funeral Home"]		NAME OF FUNERAL HOME [Faint text, possibly "The Baltimore Funeral Home"]	

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy thereof to be furnished to the funeral home or other person in charge of the funeral.

The Registrar of the Department of Health, Baltimore, Maryland, is hereby notified that the above-named deceased has died, and that the above-named funeral home or other person in charge of the funeral is in possession of the body of the deceased.

The Registrar of the Department of Health, Baltimore, Maryland, is hereby notified that the above-named deceased has died, and that the above-named funeral home or other person in charge of the funeral is in possession of the body of the deceased.

The Registrar of the Department of Health, Baltimore, Maryland, is hereby notified that the above-named deceased has died, and that the above-named funeral home or other person in charge of the funeral is in possession of the body of the deceased.

9386

CERTIFICATE OF DEATH

09379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 38	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2808 63rd Avenue		d. STREET ADDRESS 2808 63rd Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER First C Middle DEVORE Last		4. DATE OF DEATH Month AUG Day 4 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/98
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EQUIPMENT SPECIALIST, BUREAU OF SHIPS, USGov't.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES A. DEVORE		14. MOTHER'S MAIDEN NAME ELIZABETH ANDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Nora A. Devore, 2808 63rd Ave., Cheverly, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Generalized metastasis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 9 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis and Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY, 1957 to AUGUST 4, 1958 , that I last saw the deceased alive on AUGUST 4, 1958 , and that death occurred at 9:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Road DATE SIGNED August 5, 1958			
ACTUAL SIGNATURE William D. Rosson M.D.		DATE SIGNED August 5, 1958	
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON		Bladensburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/9/58	
22c. NAME OF CEMETERY OR CREMATORY Monongahela Valley Mem. Park Cemetery		22d. LOCATION (City, town, or county) (State) DONORA, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Humphrey		24a. REC'D BY REGISTRAR DATE AUG 7 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE W. J. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF PHYSICIAN</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. DATE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF WITNESSES</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF BURIAL PLACE</p>	
<p>19. SIGNATURE OF INTERVIEWER</p>		<p>20. SIGNATURE OF SUPERVISOR</p>	
<p>21. SIGNATURE OF ASSISTANT SUPERVISOR</p>		<p>22. SIGNATURE OF CLERK</p>	
<p>23. SIGNATURE OF CHIEF CLERK</p>		<p>24. SIGNATURE OF DEPUTY CHIEF CLERK</p>	
<p>25. SIGNATURE OF ASSISTANT CHIEF CLERK</p>		<p>26. SIGNATURE OF CLERK IN CHARGE</p>	
<p>27. SIGNATURE OF CLERK IN CHARGE</p>		<p>28. SIGNATURE OF CLERK IN CHARGE</p>	
<p>29. SIGNATURE OF CLERK IN CHARGE</p>		<p>30. SIGNATURE OF CLERK IN CHARGE</p>	
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<p>47. SIGNATURE OF CLERK IN CHARGE</p>		<p>48. SIGNATURE OF CLERK IN CHARGE</p>	
<p>49. SIGNATURE OF CLERK IN CHARGE</p>		<p>50. SIGNATURE OF CLERK IN CHARGE</p>	
<p>51. SIGNATURE OF CLERK IN CHARGE</p>		<p>52. SIGNATURE OF CLERK IN CHARGE</p>	
<p>53. SIGNATURE OF CLERK IN CHARGE</p>		<p>54. SIGNATURE OF CLERK IN CHARGE</p>	
<p>55. SIGNATURE OF CLERK IN CHARGE</p>		<p>56. SIGNATURE OF CLERK IN CHARGE</p>	
<p>57. SIGNATURE OF CLERK IN CHARGE</p>		<p>58. SIGNATURE OF CLERK IN CHARGE</p>	
<p>59. SIGNATURE OF CLERK IN CHARGE</p>		<p>60. SIGNATURE OF CLERK IN CHARGE</p>	
<p>61. SIGNATURE OF CLERK IN CHARGE</p>		<p>62. SIGNATURE OF CLERK IN CHARGE</p>	
<p>63. SIGNATURE OF CLERK IN CHARGE</p>		<p>64. SIGNATURE OF CLERK IN CHARGE</p>	
<p>65. SIGNATURE OF CLERK IN CHARGE</p>		<p>66. SIGNATURE OF CLERK IN CHARGE</p>	
<p>67. SIGNATURE OF CLERK IN CHARGE</p>		<p>68. SIGNATURE OF CLERK IN CHARGE</p>	
<p>69. SIGNATURE OF CLERK IN CHARGE</p>		<p>70. SIGNATURE OF CLERK IN CHARGE</p>	
<p>71. SIGNATURE OF CLERK IN CHARGE</p>		<p>72. SIGNATURE OF CLERK IN CHARGE</p>	
<p>73. SIGNATURE OF CLERK IN CHARGE</p>		<p>74. SIGNATURE OF CLERK IN CHARGE</p>	
<p>75. SIGNATURE OF CLERK IN CHARGE</p>		<p>76. SIGNATURE OF CLERK IN CHARGE</p>	
<p>77. SIGNATURE OF CLERK IN CHARGE</p>		<p>78. SIGNATURE OF CLERK IN CHARGE</p>	
<p>79. SIGNATURE OF CLERK IN CHARGE</p>		<p>80. SIGNATURE OF CLERK IN CHARGE</p>	
<p>81. SIGNATURE OF CLERK IN CHARGE</p>		<p>82. SIGNATURE OF CLERK IN CHARGE</p>	
<p>83. SIGNATURE OF CLERK IN CHARGE</p>		<p>84. SIGNATURE OF CLERK IN CHARGE</p>	
<p>85. SIGNATURE OF CLERK IN CHARGE</p>		<p>86. SIGNATURE OF CLERK IN CHARGE</p>	
<p>87. SIGNATURE OF CLERK IN CHARGE</p>		<p>88. SIGNATURE OF CLERK IN CHARGE</p>	
<p>89. SIGNATURE OF CLERK IN CHARGE</p>		<p>90. SIGNATURE OF CLERK IN CHARGE</p>	
<p>91. SIGNATURE OF CLERK IN CHARGE</p>		<p>92. SIGNATURE OF CLERK IN CHARGE</p>	
<p>93. SIGNATURE OF CLERK IN CHARGE</p>		<p>94. SIGNATURE OF CLERK IN CHARGE</p>	
<p>95. SIGNATURE OF CLERK IN CHARGE</p>		<p>96. SIGNATURE OF CLERK IN CHARGE</p>	
<p>97. SIGNATURE OF CLERK IN CHARGE</p>		<p>98. SIGNATURE OF CLERK IN CHARGE</p>	
<p>99. SIGNATURE OF CLERK IN CHARGE</p>		<p>100. SIGNATURE OF CLERK IN CHARGE</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9435

CERTIFICATE OF DEATH

Reg. Dist. No.

09380

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 22 DC</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 22 DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>				d. STREET ADDRESS <u>4935 Temple Hill Rd SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura Marie Dickens</u> First Middle Last				4. DATE OF DEATH <u>Aug 31</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharnesburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Morgan Miller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Keller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Julia Prevost Washington 22 DC</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Renal Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic hypertrophic arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>One day</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>58</u> , to <u>Aug 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 30</u> , 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C Van Natta</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5440 Silver Hill Rd SE Washington 28 DC</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C VAN Natta</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		22d. LOCATION (City, town, or county) (State) <u>Sharnesburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>				ADDRESS <u>4812 Dean Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

[The page contains faint, illegible text and two large black redaction marks.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capbox numbers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09381

9436

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avondale</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>			d. STREET ADDRESS <u>1111 Army & Navy Drive</u>		
3. NAME OF DECEASED (Type or print) <u>Victoria Laverine Di Pistoro</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 March 1879</u>		9. AGE (In years: lost birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>
13. FATHER'S NAME <u>Michael Torrillo</u>			14. MOTHER'S MAIDEN NAME <u>Filamo Gagliardi</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			17. INFORMANT <u>Rose Agnes Moran—Daughter</u>		
16. SOCIAL SECURITY NO. <u>- -</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastasis</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>26 Aug</u> , 19 <u>58</u> , to <u>30 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>26 Aug</u> , 19 <u>58</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Harry A. Horstman, Jr.</u> M.D.			ADDRESS (Street, city or town, state) <u>1835 E. 4th St NW Wash DC</u>		
PHYSICIAN'S NAME (Type) <u>Harry A. Horstman, Jr.</u>			DATE SIGNED <u>30 Aug 58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.,</u>		ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			

CERTIFICATE OF DEATH

Page 201-74

NAME OF DECEASED MARGARET J. HARRIS		AGE 62		SEX F		RACE W		DATE OF DEATH 10/15/1950		PLACE OF DEATH HOME	
RESIDENCE 1015 N. E. ST. BALTIMORE, MD.		OCCUPATION HOUSEWIFE		EDUCATION 8		MARRIAGE M		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF BIRTH 10/15/1888		PLACE OF BIRTH BALTIMORE, MD.		FATHER'S NAME JOHN HARRIS		MOTHER'S NAME MARY HARRIS		DATE OF BURIAL 10/17/1950		PLACE OF BURIAL GREENWICH CEMETERY	
DATE OF INTERVIEW 10/16/1950		INTERVIEWER J. H. HARRIS		SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF CORONER (Signature)	
DATE OF DEATH 10/15/1950		PLACE OF DEATH HOME		OCCUPATION HOUSEWIFE		EDUCATION 8		MARRIAGE M		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH 10/15/1888		PLACE OF BIRTH BALTIMORE, MD.		FATHER'S NAME JOHN HARRIS		MOTHER'S NAME MARY HARRIS		DATE OF BURIAL 10/17/1950		PLACE OF BURIAL GREENWICH CEMETERY	
DATE OF INTERVIEW 10/16/1950		INTERVIEWER J. H. HARRIS		SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF CORONER (Signature)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9387

Item 9 William 233 9-15-58 et

CERTIFICATE OF DEATH

09382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>Prince Georges</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>51 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>Brandywine</u>			
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Ann</u> Last <u>Duckett</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-14-18</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Butler</u>				14. MOTHER'S MAIDEN NAME <u>Della ANN Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Della A. Butler, Naylor, M.L.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cortical necrosis of the right kidney</u> DUE TO (b) <u>Bilateral Hydronephrosis with uremia</u> DUE TO (c) <u>Carcinoma of the Cervix Uteri</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours.</u> <u>6 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Brandywine, Md.</u>	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1 Aug., 1958</u> to <u>29 Aug., 1958</u> , that I last saw the deceased alive on <u>Aug 29</u> , 19 <u>58</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. Jones</u>				ADDRESS (Street, city or town, state) <u>Brandywine, Md.</u>		DATE SIGNED <u>8-29-58</u>	
PHYSICIAN'S NAME (Type) <u>J. B. Jones</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>9/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sanctifier</u>		22d. LOCATION (City, town, or county) (State) <u>Brandywine, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home, Waldorf, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 4 58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

1957

CERTIFICATE OF DEATH

1957

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1/1/1912		1/15/1957		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of completion		18. Signature of informant		19. Signature of registrar		20. Signature of physician	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		1/16/1957		[Signature]		[Signature]		[Signature]	

1957

1957

1957

CERTIFICATE OF DEATH

Reg. Dist. No.

9388

09388

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Percy First Middle Last Duvall			4. DATE OF DEATH Month Day Year August 17 1958		
5. SEX Male	6. COLOR OR RACE White	7. WEDDED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-20-73	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret. Justice of Peace-Circuit Ct.			10b. KIND OF BUSINESS OR INDUSTRY County		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Benjamin Franklin Duvall		
14. MOTHER'S MAIDEN NAME Susan Jane Sasscer			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. --			17. INFORMANT Catherine Burroughs Address Upper Marlboro, Md.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular DUE TO (c) Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 8 days 6 gm
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - Possible Carcinoma Prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **August 12, 1958**, to **August 17, 1958**, that I last saw the deceased alive on **August 17, 1958**, and that death occurred at **6:10 A.M.** from the causes and on the date stated above.

ACTUAL SIGNATURE James E. Janner M.D.	ADDRESS (Street, city or town, state) Upper Marlboro, Md.	DATE SIGNED 8/17/58
PHYSICIAN'S NAME (Type) Dr. James Sasscer, M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 19, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	22d. LOCATION (City, town, or county) (State) Groom Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24a. REC'D BY REGISTRAR AUG 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09384

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt #2 Box 353</u>				d. STREET ADDRESS <u>Rt #2 Box 353</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Viola Early</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 3, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>18</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>18</u> Hours <u>18</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Telephone Plant, Naval Radio Sta</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John White</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hutchinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1661-60040</u>		17. INFORMANT <u>Leonard Early, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO <u>Hemorrhage and shock</u> Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound of head</u> (c) <u>stating the underlying cause last.</u></p> </div> <div style="width: 55%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERNAL BETWEEN ONSET AND DEATH</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self in head with 32 Calpers</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:00 p.m. Aug 18 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Clinton P. G. Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 18, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Severland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				ADDRESS <u>1661-60040</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 20 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09385

9389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. LENGTH OF STAY IN 1b 29			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 50 D. Cresent Road				d. STREET ADDRESS 50 D. Cresent Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle Julian Last Faulconer				4. DATE OF DEATH Month August Day 5 Year 19 58			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William H. Faulconer				14. MOTHER'S MAIDEN NAME Mary Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-26-4894		17. INFORMANT Agnes C. Faulconer; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lung DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				DATE SIGNED August 5, 1958			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/58		22c. NAME OF CEMETERY OR CREMATORY Locas Grove		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR AUG 7 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alfred</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALT. MORE 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased William E. Tomlinson		Date of Death March 25, 1923	
Sex Male		Race White	
Age 35		Birth Date March 25, 1888	
Place of Birth Virginia		Usual Residence Baltimore, Md.	
Cause of Death Coronary Artery Disease		Manner of Death Natural	
Signature of Physician John T. McNamee, M.D.		Signature of Medical Examiner [Signature]	
Date of Signature April 2, 1923		Date of Signature [Date]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9438

CERTIFICATE OF DEATH

Reg. Dist. No.

09386

1. PLACE OF DEATH a. COUNTY <u>P. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Go</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel B7H</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 R. F. D. Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Marie</u> Last <u>Fauntman</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>23</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince Georges Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nan Tilling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXXXXX</u>	
17. INFORMANT <u>Hazel one Clinton Laurel</u> Address <u>Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General aneurysm - myocardial</u> <u>592x</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension - aortic stenosis</u> DUE TO <u>myocardial - chr int</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>53</u> , to <u>8/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/23/58</u> , 19 <u>58</u> , and that death occurred at <u>62</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N B Steward</u> M.D.		ADDRESS (Street, city or town, state) <u>314 Conyngham</u> DATE SIGNED <u>8/23/58</u>	
PHYSICIAN'S NAME (Type) <u>N B Steward</u>		<u>Laurel M</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1925</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. PERIOD OF ILLNESS <i>2 weeks</i>	
10. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>W. J. Brown</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>W. J. Brown</i>		14. SIGNATURE OF CLERK <i>W. J. Brown</i>		15. SIGNATURE OF JURY <i>W. J. Brown</i>	
16. SIGNATURE OF JURY <i>W. J. Brown</i>		17. SIGNATURE OF JURY <i>W. J. Brown</i>		18. SIGNATURE OF JURY <i>W. J. Brown</i>	
19. SIGNATURE OF JURY <i>W. J. Brown</i>		20. SIGNATURE OF JURY <i>W. J. Brown</i>		21. SIGNATURE OF JURY <i>W. J. Brown</i>	
22. SIGNATURE OF JURY <i>W. J. Brown</i>		23. SIGNATURE OF JURY <i>W. J. Brown</i>		24. SIGNATURE OF JURY <i>W. J. Brown</i>	
25. SIGNATURE OF JURY <i>W. J. Brown</i>		26. SIGNATURE OF JURY <i>W. J. Brown</i>		27. SIGNATURE OF JURY <i>W. J. Brown</i>	
28. SIGNATURE OF JURY <i>W. J. Brown</i>		29. SIGNATURE OF JURY <i>W. J. Brown</i>		30. SIGNATURE OF JURY <i>W. J. Brown</i>	
31. SIGNATURE OF JURY <i>W. J. Brown</i>		32. SIGNATURE OF JURY <i>W. J. Brown</i>		33. SIGNATURE OF JURY <i>W. J. Brown</i>	
34. SIGNATURE OF JURY <i>W. J. Brown</i>		35. SIGNATURE OF JURY <i>W. J. Brown</i>		36. SIGNATURE OF JURY <i>W. J. Brown</i>	
37. SIGNATURE OF JURY <i>W. J. Brown</i>		38. SIGNATURE OF JURY <i>W. J. Brown</i>		39. SIGNATURE OF JURY <i>W. J. Brown</i>	
40. SIGNATURE OF JURY <i>W. J. Brown</i>		41. SIGNATURE OF JURY <i>W. J. Brown</i>		42. SIGNATURE OF JURY <i>W. J. Brown</i>	
43. SIGNATURE OF JURY <i>W. J. Brown</i>		44. SIGNATURE OF JURY <i>W. J. Brown</i>		45. SIGNATURE OF JURY <i>W. J. Brown</i>	
46. SIGNATURE OF JURY <i>W. J. Brown</i>		47. SIGNATURE OF JURY <i>W. J. Brown</i>		48. SIGNATURE OF JURY <i>W. J. Brown</i>	
49. SIGNATURE OF JURY <i>W. J. Brown</i>		50. SIGNATURE OF JURY <i>W. J. Brown</i>		51. SIGNATURE OF JURY <i>W. J. Brown</i>	
52. SIGNATURE OF JURY <i>W. J. Brown</i>		53. SIGNATURE OF JURY <i>W. J. Brown</i>		54. SIGNATURE OF JURY <i>W. J. Brown</i>	
55. SIGNATURE OF JURY <i>W. J. Brown</i>		56. SIGNATURE OF JURY <i>W. J. Brown</i>		57. SIGNATURE OF JURY <i>W. J. Brown</i>	
58. SIGNATURE OF JURY <i>W. J. Brown</i>		59. SIGNATURE OF JURY <i>W. J. Brown</i>		60. SIGNATURE OF JURY <i>W. J. Brown</i>	
61. SIGNATURE OF JURY <i>W. J. Brown</i>		62. SIGNATURE OF JURY <i>W. J. Brown</i>		63. SIGNATURE OF JURY <i>W. J. Brown</i>	
64. SIGNATURE OF JURY <i>W. J. Brown</i>		65. SIGNATURE OF JURY <i>W. J. Brown</i>		66. SIGNATURE OF JURY <i>W. J. Brown</i>	
67. SIGNATURE OF JURY <i>W. J. Brown</i>		68. SIGNATURE OF JURY <i>W. J. Brown</i>		69. SIGNATURE OF JURY <i>W. J. Brown</i>	
70. SIGNATURE OF JURY <i>W. J. Brown</i>		71. SIGNATURE OF JURY <i>W. J. Brown</i>		72. SIGNATURE OF JURY <i>W. J. Brown</i>	
73. SIGNATURE OF JURY <i>W. J. Brown</i>		74. SIGNATURE OF JURY <i>W. J. Brown</i>		75. SIGNATURE OF JURY <i>W. J. Brown</i>	
76. SIGNATURE OF JURY <i>W. J. Brown</i>		77. SIGNATURE OF JURY <i>W. J. Brown</i>		78. SIGNATURE OF JURY <i>W. J. Brown</i>	
79. SIGNATURE OF JURY <i>W. J. Brown</i>		80. SIGNATURE OF JURY <i>W. J. Brown</i>		81. SIGNATURE OF JURY <i>W. J. Brown</i>	
82. SIGNATURE OF JURY <i>W. J. Brown</i>		83. SIGNATURE OF JURY <i>W. J. Brown</i>		84. SIGNATURE OF JURY <i>W. J. Brown</i>	
85. SIGNATURE OF JURY <i>W. J. Brown</i>		86. SIGNATURE OF JURY <i>W. J. Brown</i>		87. SIGNATURE OF JURY <i>W. J. Brown</i>	
88. SIGNATURE OF JURY <i>W. J. Brown</i>		89. SIGNATURE OF JURY <i>W. J. Brown</i>		90. SIGNATURE OF JURY <i>W. J. Brown</i>	
91. SIGNATURE OF JURY <i>W. J. Brown</i>		92. SIGNATURE OF JURY <i>W. J. Brown</i>		93. SIGNATURE OF JURY <i>W. J. Brown</i>	
94. SIGNATURE OF JURY <i>W. J. Brown</i>		95. SIGNATURE OF JURY <i>W. J. Brown</i>		96. SIGNATURE OF JURY <i>W. J. Brown</i>	
97. SIGNATURE OF JURY <i>W. J. Brown</i>		98. SIGNATURE OF JURY <i>W. J. Brown</i>		99. SIGNATURE OF JURY <i>W. J. Brown</i>	
100. SIGNATURE OF JURY <i>W. J. Brown</i>		101. SIGNATURE OF JURY <i>W. J. Brown</i>		102. SIGNATURE OF JURY <i>W. J. Brown</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9439

CERTIFICATE OF DEATH

Reg. Dist. No.

09387

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHILLUM</i>	c. LENGTH OF STAY IN 1b <i>3 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Chillum</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1413 MADISON ST.</i>		d. STREET ADDRESS <i>1413 Madison St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>Genevieve</i> Last <i>Finegon</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 23, 1875</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William O'heary</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine O'Hare.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Gertrude Finegon 1413 Madison St. Chillum Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, generalized, severe</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>many years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 17, 1958</i> to <i>Aug 22, 1958</i> , that I last saw the deceased alive on <i>Aug 17, 1958</i> , and that death occurred at <i>7:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William F Simpson</i>		DATE SIGNED <i>8/22/58</i>	
PHYSICIAN'S NAME (Type) <i>William F Simpson</i>		<i>Washington, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-26-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Name Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Jersey City, N.J.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J Collins</i>		24a. REC'D BY REGISTRAR <i>38214</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		24c. DATE <i>AUG 25 '58</i>	

9390

CERTIFICATE OF DEATH

Reg. Dist. No.

09388

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Beach</u> <u>04X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>202 Dayton Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>VIRGINIA</u> Last <u>Garner</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/31/26</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Lehr</u>				14. MOTHER'S MAIDEN NAME <u>Queenie Whittaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Robert E. Garner</u> Address <u>309-7th St. North Beach Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF CERVIX</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>27 RS</u> <u>374</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>8/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/6</u> , 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8-6-58</u>							
ACTUAL SIGNATURE <u>John Keohoe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. John Keohoe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers to Ina</u> ADDRESS <u>517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filled with the registrar prior to burial/cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9357

CERTIFICATE OF DEATH

Reg. Dist. No.

09389

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WASHINGTON, D.C. County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		d. STREET ADDRESS 1713 IRVING STREET	
3. NAME OF DECEASED (Type or print) First TERESA Middle M. Last GILMORE		4. DATE OF DEATH Month AUGUST Day 31 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? UNKNOWN
9. AGE (In years last birthday) yrs. 80+		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC WORK		10b. KIND OF BUSINESS OR INDUSTRY IRELAND	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? IRELAND ✓	
13. FATHER'S NAME JOSEPH GILMORE		14. MOTHER'S MAIDEN NAME AGNES LOUGHRAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-44-3283	
17. INFORMANT Sister M. Jean Therien		Address Hyattsville Md. 4922 La Salle Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory depression DUE TO Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shock DUE TO Myocardial infarct - acute (c) Myocardial infarct - acute			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/31, 1958 , to 9/2, 1958 , that I last saw the deceased alive on Aug 31, 1958 , and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard J. Melaney M.D.			
ACTUAL SIGNATURE Richard J. Melaney			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/2/1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington DC
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Jewell's Sons, Inc.		24a. REC'D BY REGISTRAR DATE SEP 4 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

9440

CERTIFICATE OF DEATH

Reg. Dist. No.

09390

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington, D. C. 47X-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Newborn Infant Son Gonzales				4. DATE OF DEATH Month Day Year August 3 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 August 1958	9. AGE (In years last birthday) yrs. 15	IF UNDER 1 YEAR Months Days Hours Min. 15 10	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Marcilos Andrew Gonzales				14. MOTHER'S MAIDEN NAME Mary Elizabeth Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father, 4807 Alabama Ave, S.E. Wash., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 9 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Not Applicable				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2 August 1958, to 3 August 1958, that I last saw the deceased alive on 3 August 1958, and that death occurred at 2:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews 3 August 1958							
ACTUAL SIGNATURE Douglas E. Pierce				M.D. USAF Hospital Andrews			
PHYSICIAN'S NAME (Type) DOUGLAS E. PIERCE, CAPT, USAF (MC) Andrews Air Force Base, Washington 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) FT. MYER, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi's Funeral Home, Washington, D.C.				24a. REC'D BY REGISTRAR DATE AUG 7 '58		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

SEE OUT 124

LAST OF DEATH		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
PLACE OF DEATH		PLACE OF MARRIAGE	
NAME OF DECEASED		NAME OF SPOUSE	
AGE OF DECEASED		AGE OF SPOUSE	
SEX OF DECEASED		SEX OF SPOUSE	
RACE OF DECEASED		RACE OF SPOUSE	
EDUCATION OF DECEASED		EDUCATION OF SPOUSE	
OCCUPATION OF DECEASED		OCCUPATION OF SPOUSE	
RELIGION OF DECEASED		RELIGION OF SPOUSE	
CAUSE OF DEATH		CAUSE OF DEATH	
PLACE OF BURIAL		PLACE OF BURIAL	
DATE OF BURIAL		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
NAME OF MINISTER		NAME OF MINISTER	
NAME OF CHURCH		NAME OF CHURCH	
NAME OF CEMETERY		NAME OF CEMETERY	
NAME OF INTERVIEWER		NAME OF INTERVIEWER	
DATE OF INTERVIEW		DATE OF INTERVIEW	
SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE	
SIGNATURE OF MINISTER		SIGNATURE OF MINISTER	
SIGNATURE OF CHURCH		SIGNATURE OF CHURCH	
SIGNATURE OF CEMETERY		SIGNATURE OF CEMETERY	
SIGNATURE OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
DATE OF SIGNATURE		DATE OF SIGNATURE	



156101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9391

Reg. Dist. No. 09391

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Page	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b. D.O.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stanley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Route 1. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luther Middle Leon Last Good		4. DATE OF DEATH Month August Day 1, Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1908 9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Madison Good		14. MOTHER'S MAIDEN NAME Anna Lowery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service W.W.2		16. SOCIAL SECURITY NO. 223-18-8232 17. INFORMANT Address Annie Pauline Good; same address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 1, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 3, 1958 22c. NAME OF CEMETERY OR CREMATORY Family Cemetery	
22d. LOCATION (City, town, or county) (State) Stanley Virginia		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.	
24a. REC'D BY REGISTRAR AUG 5 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

FOR STATE
HEALTH DEPT

1201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1201

NAME OF DECEASED		JAMES H. HANCOCK	
AGE		70	
SEX		Male	
RACE		White	
DATE OF BIRTH		October 3, 1893	
PLACE OF BIRTH		Virginia	
CITY OF BIRTH		U.S.A.	
RESIDENCE		James H. Hancock, 1000	
STREET		U.S.A.	
CITY		Baltimore	
STATE		Maryland	
DATE OF DEATH		October 3, 1963	
PLACE OF DEATH		Home	
CITY OF DEATH		Baltimore	
STATE OF DEATH		Maryland	
CAUSE OF DEATH		Cardiovascular, renal disease	
MANNER OF DEATH		Natural	
SIGNATURE OF EXAMINER		J. H. Hancock	
DATE OF EXAMINATION		October 3, 1963	
PLACE OF EXAMINATION		Home	
CITY OF EXAMINATION		Baltimore	
STATE OF EXAMINATION		Maryland	
SIGNATURE OF WITNESS		J. H. Hancock	
DATE OF WITNESS		October 3, 1963	
PLACE OF WITNESS		Home	
CITY OF WITNESS		Baltimore	
STATE OF WITNESS		Maryland	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 6, 14, Film 232 8-20-58 et

Reg. Dist. No.

9392

09392

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5901 Sheriff Road, N.E.	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Celestina Last Green		4. DATE OF DEATH Month August Day 10th Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-22
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Dorothy Crabbe; 3984 East Capitol St, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stab wounds of chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stabbed in back with a knife held by another person.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed in back with a knife held by another person.	
20c. TIME OF INJURY Month, Day, Year 11.45 p.m. 8-9-1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard at home		20f. (City or town) (County) (State) Fairmount Heights, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED August 10, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-13-58		22b. DATE THEREOF 8-13-58	
22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, town, or county) (State) Suitland Rd Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
ADDRESS 467 N ST NW		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

MEDICAL CERTIFICATION

2

2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Talbot, Jr.	
Age		8-12-28	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Residence		1000 North Avenue, Baltimore, Md.	
Cause of Death		Sudden death	
Manner of Death		Natural	
Place of Death		Home	
Date of Death		August 10, 1928	
Time of Death		10:00 AM	
Physician		Dr. J. H. Talbot	
Medical Examiner		Dr. J. H. Talbot	
Signature		[Signature]	
Date		August 10, 1928	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9441

CERTIFICATE OF DEATH

Reg. Dist. No.

09393

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>15132 Farmville Rd S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Gregg</u> Last <u>Gregg</u>				4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-31-1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Stuart, Gt. Prop.</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Gregg</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Blue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-3472</u>		17. INFORMANT <u>Nancy Ann Mrs. Knight</u> Address <u>5132 Farmville Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>General Vascular Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus, mod. inv.</u> (c) <u>Arteriosclerosis generalized - hardened</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 yrs.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-16</u> , 19 <u>57</u> , to <u>8-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-5</u> , 19 <u>58</u> , and that death occurred at <u>7:40</u> P. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John J. Chace</u> M.D. <u>3801 Ga. Ave. N.W. D.C.</u>							
PHYSICIAN'S NAME (Type) <u>John J. Chace M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Stanton</u> ADDRESS <u>3831 Ga. Ave. N.W. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Redmond</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9393

CERTIFICATE OF DEATH

Reg. Dist. No.

09394

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William L Gross		4. DATE OF DEATH Aug 21 19 58	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/4/78	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT HOSP. RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Adeno carcinoma of the rectum DUE TO (b) Carcinomatous DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11, 19 58, to 8-21, 19 58, that I last saw the deceased alive on Aug 21, 19 58, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C.C. Hageage		ADDRESS (Street, city or town, state) M.D. 3308 Perry St. Mt. Rainier, Md.	
PHYSICIAN'S NAME (Type) C.C. Hageage		DATE SIGNED 8/21/58	
22a. BURIAL, CREMATION, or DISPOSAL (Specify) BURIAL		22b. DATE THEREOF AUG. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) SUITLAND MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Arnoldi Funeral Home		ADDRESS 816 H. St. E.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE AUG 25 58			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		White		Jan 15, 1920		10:30 AM		Home		Heart Disease		Natural		J. Smith		A. Jones		B. Brown	
13. Date of birth		14. Place of birth		15. Usual residence		16. Occupation		17. Marital status		18. Education		19. Religion		20. Social status		21. Previous illness		22. Last illness		23. Last medical attention		24. Last meal	
Jan 1, 1875		Maryland		Baltimore		Clerk		Married		High School		Catholic		Middle Class		None		Heart Trouble		Jan 10, 1920		Jan 14, 1920	
25. Name of informant		26. Address of informant		27. Telephone number		28. Name of physician		29. Address of physician		30. Telephone number		31. Name of registrar		32. Address of registrar		33. Telephone number		34. Name of informant		35. Address of informant		36. Telephone number	
C. Green		123 Main St		456-7890		D. White		789 Main St		987-6543		E. Black		321 Main St		234-5678		F. Blue		654 Main St		876-5432	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3 and 4 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9394

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09395

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 21 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. d. STREET ADDRESS 2619 Nicholson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Byron First Middle Last Halloran Jr.		4. DATE OF DEATH Month Day Year August 11 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 58
9. AGE (In years last birthday) 21		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard B. Halloran Sr.		14. MOTHER'S MAIDEN NAME Do Ann E. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMATION Father as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545 DUE TO Cong. heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Cor. Prelocular) DUE TO (c) 21 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 58 , 19 58 , to August 11, 19 58 , that I last saw the deceased alive on August 11, 19 58 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4309 Riggs Rd West Hyattsville Md. DATE SIGNED			
ACTUAL SIGNATURE Joseph McDonald M.D.		PHYSICIAN'S NAME (Type) Dr. Joseph McDonald	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-58	
22c. NAME OF CEMETERY OR CREMATORY Washington National Cme.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR Aug 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		ADDRESS Hyattsville, Maryland	

2077221XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9442

CERTIFICATE OF DEATH

Reg. Dist. No.

09396

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs., 11 mos., and 16 days.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>919 Eye St., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>S.</u> Last <u>Hammett</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/08</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chastleton Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William C. Hammett</u>				14. MOTHER'S MAIDEN NAME <u>Jennie McIntire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-12-8372</u>		17. INFORMANT <u>Decedent</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO (b) <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>-</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs., 11 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/9</u> , 19 <u>55</u> , to <u>8/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>58</u> , and that death occurred at <u>1:25A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>			
DATE SIGNED <u>8/25/58</u>							
PHYSICIAN'S NAME (Type) <u>Moé Weiss, M. D.</u>				<u>Glenn Dale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/27/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Rinaldi Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home</u>				ADDRESS <u>816 H. H. St.</u>		24a. REC'D BY REGISTRAR <u>AUG 29 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09397

Reg. Dist. No.

9358

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1805 Fox Street Apt 102		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harvey Wesley Haun		4. DATE OF DEATH August 14 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Government Clerk Illinois	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Clark Haun		14. MOTHER'S MAIDEN NAME Cordelia Lemon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-48-0537	
17. INFORMANT Wida Miller Haun-1805 Fox Street Hyattsville, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis - Right Side		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Aug., 1958 to 14 Aug., 1958 , that I last saw the deceased alive on 13 Aug., 1958 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Russell B. Arnold M.D.		ADDRESS (Street, city or town, state) 8801 Colesville Road, Silver Spring, Md. 142	
PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		DATE SIGNED 8/14/58	
22a. BURIAL, CREMATION, REMOVAL SPECIAL burial		22b. DATE THEREOF 8/16/58	
22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St., N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Place of Report	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09398

9359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>1854 Wyoming</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Blanche</u> Last <u>Herbert</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17 1869</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>J. Wells Herbert</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Sister M. Joan Therese - CARROLL MANOR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Aug 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 23</u> , 19 <u>58</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Egan</u>				ADDRESS (Street, city or town, state) <u>7720 Wisconsin Ave. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James W. Egan</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8/29/58</u>		<u>OAK HILL Cem.</u>		<u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulsen</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaut</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1900	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
JAN 20 1945		BALTIMORE, MARYLAND		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9395

Reg. Dist. No. 09399

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1, 2, and 3 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u>	
c. LENGTH OF STAY IN ID <u>36</u>		d. STREET ADDRESS <u>1401-48th Avenue</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roy Wesley Jandrew</u>		4. DATE OF DEATH <u>August 26 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1893</u>
9. AGE (in years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Jandrew</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baxter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>with</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wesley Jandrew, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute Congestive heart failure</u>			
(b) <u>Cardiovascular renal disease</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 29 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SVITLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. LEE</u> ADDRESS <u>300 4th ST. N.E. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

9396

CERTIFICATE OF DEATH

Reg. Dist. No.

89460

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 6800 Greigg St.	
3. NAME OF DECEASED (Type or print) First Bab y Middle Girl "A" Last Jeter		4. DATE OF DEATH Month August Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Aug 1958
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest A. Jeter		14. MOTHER'S MAIDEN NAME Billie L McCauley Craine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Bilateral pulmonary atelectasis DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug 1958 to 20 Aug 1958 , that I last saw the deceased alive on 19 Aug 1958 , and that death occurred at 3:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G Maloney M.D.		DATE SIGNED 20 Aug 58	
PHYSICIAN'S NAME (Type) Dr. Thomas G Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/26/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR SEP 4 '58	
ADDRESS Administrator.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077283XVI

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF CHILD

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF CHILD

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF CHILD

DATE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detachably for use as the burial-transit permit. Then please remove carbon 3. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9397

CERTIFICATE OF DEATH

Reg. Dist. No.

09491

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl "B"		4. DATE OF DEATH Month August Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) yrs. 1 Months 10 Days 35 Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Jeter		14. MOTHER'S MAIDEN NAME Billie J Mc Craine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Billie Jeter 6800 Greig St. Seat Pleasant	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 762.5 Bilateral pulmonary atelectasis DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1958 , to August 19, 1958 , that I last saw the deceased alive on August 19, 1958 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Maloney		ADDRESS (Street, city or town, state) 4814-71st Ave.	
PHYSICIAN'S NAME (Type) Dr. Hershberg		DATE SIGNED 19 Aug 58	
22a. BURIAL, CREMATION, RE MOVAL (Specify) cremation		22b. DATE THEREOF 8/26/58;	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Narry W. Penn, Jr.		24a. REC'D BY REGISTRAR SEP 4 '58	
ADDRESS Administrator		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

IMMEDIATE

EX-100

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1900



<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>	
<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of attending physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Date of registration: _____</p>	
<p>11. Place of registration: _____</p>	
<p>12. Remarks: _____</p>	

RECEIVED
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
NEW YORK CITY
JAN 10 1901

9398

Item 12. See: Birth Cert. et
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kenney Middle Baby Last Boy				4. DATE OF DEATH Month Aug. Day 18 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Aug. 1958		9. AGE (In years last birthday) yrs. 9	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Hours 9 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? yes USA
13. FATHER'S NAME John Kenney				14. MOTHER'S MAIDEN NAME June Carroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Belond		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.2 Dissection Pneumonia DUE TO (b) Cong. 1st. Disease (U. S. p. Tol defect) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 Aug. 1958 , to 18 Aug. 1958 , that I last saw the deceased alive on 18 Aug 1958 , and that death occurred at 1,30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John Kehoe M.D.							
PHYSICIAN'S NAME (Type) Dr. John Kehoe, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/58		22c. NAME OF CEMETERY OR CREMATORY St. Oliver Cemetery Washington		22d. LOCATION (City, town, or county) (State) AC	
23. FUNERAL DIRECTOR'S SIGNATURE AEHOL Funeral Home 2224 Wilson				24a. REC'D BY REGISTRAR Aug 19 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2077406XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

NAME OF DECEASED [Handwritten: Mary Jane Smith]		SEX [Handwritten: Female]		AGE [Handwritten: 65]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		OCCUPATION [Handwritten: None]		CAUSE OF DEATH [Handwritten: Heart Failure]	
DATE OF DEATH [Handwritten: Jan 15, 1925]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESSES [Blank]		SIGNATURE OF PHYSICIAN [Blank]	
SIGNATURE OF CLERK [Blank]		SIGNATURE OF REGISTRAR [Blank]		SIGNATURE OF JUDGE [Blank]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9399 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09403

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>Read on arrival</u> x <u>Switzerland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>14715 Sunset Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Douglas Koontz</u>		First Middle Last		4. DATE OF DEATH Month Day Year <u>Aug 27 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 9, 1873</u>	
				9. AGE (In years (or birth date)) <u>84</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTH PLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Koontz</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>130-03-1532</u>		17. INFORMANT <u>Walter D. Koontz Jr same as father</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular Renal disease</u> (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>NAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 28, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pineville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mc Gaheyville Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9443

CERTIFICATE OF DEATH

09404

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		c. LENGTH OF STAY IN 1b 4 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9411 VAN Buren ST		d. STREET ADDRESS 9411 VAN Buren ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last Kuehl		4. DATE OF DEATH Month Aug Day 25 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 5 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Doherty		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT husband mr Arthur CARL Kuehl		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH , 1958, to Aug 25 , 1958, that I last saw the deceased alive on Aug 25 , 1958, and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 8/25/58			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		M.D.	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU M.D. MTRAINIER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/26/58	
22c. NAME OF FUNERAL HOME New Haven, Conn.		22d. LOCATION (City, town, or county) (State) New Haven, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch		ADDRESS Sons Hyattsville, Maryland	
24a. REC'D BY REGISTRAR AUG 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1943

NAME OF DECEASED: James Joseph
AGE: 38
SEX: Male
DATE OF BIRTH: 1905
PLACE OF BIRTH: St. Louis, Mo.
OCCUPATION: Electrician
CAUSE OF DEATH: Myocardial Infarction
DATE OF DEATH: 10/15/43
PLACE OF DEATH: St. Vincent's Hospital, Boston
SIGNATURE OF PHYSICIAN: Dr. J. J. [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: 10/20/43

9400

CERTIFICATE OF DEATH

Reg. Dist. No.

09405

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3500 Cheverly Ave.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 38 d. STREET ADDRESS 3500 Cheverly Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Biddie Esther Lindsay 4. DATE OF DEATH Month Day Year August 6, 1958				5. SEX F. W. 6. COLOR OR RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 18, 1883 9. AGE (In years last birthday) yrs. 75 IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Webber 14. MOTHER'S MAIDEN NAME Betty Gilespi				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. ? 17. INFORMANT Mrs. Bernice Hunt Address 3500 Cheverly Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 min 10 yrs				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia CVA - 57h previously</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1 Jan</u> , 19 <u>57</u> , to <u>6 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 Aug</u> , 19 <u>58</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John Kehoe M.D. 8/6/58 John Kehoe 3404 Cheverly Ave. Cheverly, Md.			
22a. BURIAL, CREMATION OR REMOVAL (Specify) 22b. DATE THEREOF 8/8/58 22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery 22d. LOCATION (City, town, or county) (State) Roanoke, Va.				23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons ADDRESS Jos. Gawler's Sons Inc. 1756 Pa. Ave. N. 24a. REC'D BY REGISTRAR DATE AUG 11 '58 24b. REGISTRAR'S SIGNATURE Allan Smith			

CERTIFICATE OF DEATH

09406

Reg. Dist. No.

9444

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASH. D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>6 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7201 BOOKER DR.</u>				d. STREET ADDRESS <u>47X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>INFANT</u> Middle <u>OF</u> Last <u>MARGIE LOVE</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-52</u>	9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>22</u> Days <u>1</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JAMES LOVE</u>				14. MOTHER'S MAIDEN NAME <u>MARGIE ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. JUDITH RODGERS</u> Address <u>7201 BOOKER DR. HUNTSVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>VIRAL RESPIRATORY INFECTION</u> DUE TO (c) <u>1 DAY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>—</u> p. m.	Month, <u>19</u>	Day, <u>19</u>	Year, <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>2-11</u> , 19 <u>58</u> to <u>2-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>58</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7220 Booker Dr. Huntsville</u>							
ACTUAL SIGNATURE <u>Dr. W. C. Code</u>				DATE SIGNED <u>2-12-58</u>			
PHYSICIAN'S NAME (Type) <u>Johnson & Jenkins</u>				ADDRESS <u>4804 P.A. Ave. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins</u>				24. REC'D BY REGISTRAR <u>Aug 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and retain them for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVXVV

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15, 1925</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Feb 10, 1970</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEXT OF KIN <i>John Doe</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF CHURCH CLERK <i>John Doe</i>	
19. SIGNATURE OF MINISTER <i>John Doe</i>		20. SIGNATURE OF BURIAL CLERK <i>John Doe</i>	
21. SIGNATURE OF INTERMENT CLERK <i>John Doe</i>		22. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
23. SIGNATURE OF OTHER CLERK <i>John Doe</i>		24. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
25. SIGNATURE OF OTHER CLERK <i>John Doe</i>		26. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
27. SIGNATURE OF OTHER CLERK <i>John Doe</i>		28. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
29. SIGNATURE OF OTHER CLERK <i>John Doe</i>		30. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
31. SIGNATURE OF OTHER CLERK <i>John Doe</i>		32. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
33. SIGNATURE OF OTHER CLERK <i>John Doe</i>		34. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
35. SIGNATURE OF OTHER CLERK <i>John Doe</i>		36. SIGNATURE OF OTHER CLERK <i>John Doe</i>	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESS
15. SIGNATURE OF DECEASED
16. SIGNATURE OF NEXT OF KIN
17. SIGNATURE OF CLERK
18. SIGNATURE OF CHURCH CLERK
19. SIGNATURE OF MINISTER
20. SIGNATURE OF BURIAL CLERK
21. SIGNATURE OF INTERMENT CLERK
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 29 Avondale Street	
3. NAME OF DECEASED (Type or print) James Edgar Mallonee		4. DATE OF DEATH August 3, 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1892
9. AGE (in years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Leonard J. Mallonee		14. MOTHER'S MAIDEN NAME Margaret Ann Houston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 1		16. SOCIAL SECURITY NO. Edith G. Hiatt; 409 4th St., Laurel, Md.	
17. INFORMANT Edith G. Hiatt; 409 4th St., Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous intracranial hemorrhage (c) Cerebral arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED August 3, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 6, 1958		22b. DATE THEREOF Aug 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Stuy Hill Cem.		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Randolph, Laurel Md		24a. REC'D BY REGISTRAR Aug 8 '58	
ADDRESS Laurel Md		24b. REGISTRAR'S SIGNATURE De Witt Randolph	



STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Mahoney	
Sex		Male	
Age		35-40 years	
Race		White	
Birthplace		New York	
Residence		New York	
Cause of Death		Spontaneous intracerebral hemorrhage	
Manner of Death		Natural	
Signature of Medical Examiner		<i>John T. Mahoney</i>	
Date		August 1, 1938	

9402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale, Maryland.			
c. LENGTH OF STAY IN 1b 82 years				d. STREET ADDRESS 1 6017 Good Luck Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6017 Good Luck Road,.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Charles Maske Sr.				4. DATE OF DEATH Month Day Year August 22, 1958;			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 3, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Charles Maske				14. MOTHER'S MAIDEN NAME Antionette Dryer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Address Antionette Hamel Riverdale, Maryland.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957, to Aug 22, 1958, that I last saw the deceased alive on 8-22, 1958, and that death occurred at 11:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. Leonard Hays M.D. Hyattsville, Md. PHYSICIAN'S NAME (Type) 5201 Balt. Ave.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF DEATH Aug 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE AUG 28 1958	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and place them in the envelope provided. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9445

CERTIFICATE OF DEATH

09409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo. W. Lanham</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville P.O.Md.</i>				c. LENGTH OF STAY IN 1b <i>3 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7754 Decatur Road (West Lanham Hills)</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7754 Decatur Road (West Lanham Hills)</i>				d. STREET ADDRESS <i>4114 Emery Place.N.W.</i>			
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>ELLEN</i> Last <i>MCCONVEY</i>				4. DATE OF DEATH Month <i>August</i> Day <i>20th</i> , Year <i>19 58</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 6th, 1856</i>	
9. AGE (In years last birthday) <i>102</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer--Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>			
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Henry T. McConvey</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Burke</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Mrs. Albert B. Hitt, 7754 Decatur Road, Hyattsville P.O.Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA</i> DUE TO <i>491X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>491X</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>5</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PULMONARY EMPHYSEMA</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>15 Aug, 1958</i> , to <i>20 Aug, 1958</i> , that I last saw the deceased alive on <i>20 Aug, 1958</i> , and that death occurred at <i>12:40 P.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Hyattsville Md.</i>				DATE SIGNED <i>21 Aug 58</i>			
ACTUAL SIGNATURE <i>Thomas G. Maloney</i> M.D.							
PHYSICIAN'S NAME (Type) <i>THOMAS G. MALONEY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/23/1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Pr. Geo. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Company, Washington, D.C.</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

THE REG. NO.

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Sex]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Marital status]</p>		<p>8. CAUSE OF DEATH [Cause of death]</p>	
<p>9. DATE OF DEATH [Date of death]</p>		<p>10. TIME OF DEATH [Time of death]</p>	
<p>11. PLACE OF DEATH [Place of death]</p>		<p>12. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>13. SIGNATURE OF WITNESS [Signature of witness]</p>		<p>14. SIGNATURE OF PHYSICIAN [Signature of physician]</p>	
<p>15. SIGNATURE OF CLERK [Signature of clerk]</p>		<p>16. SIGNATURE OF REGISTRAR [Signature of registrar]</p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Landover Knolls d. STREET ADDRESS 3806 65 Ave. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John H Jr. Mc Gauchy			4. DATE OF DEATH Month August Day 2 Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/08		9. AGE (In years last birthday) yrs. 50		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Civil Aeronautics		11. BIRTHPLACE (State or foreign country) Washington D.C.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME United States					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Bernice Mc Gauchy 3806 65 Ave Landover Knolls			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction with Interventricular Rupture 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion, left anterior descending DUE TO (c) Coronary Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 48 hours years					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from July 31 , 19 58 , to August 2 , 19 58 , that I last saw the deceased alive on August 2 , 19 58 , and that death occurred at 9:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt Rainier Md. DATE SIGNED 8.2.58 ACTUAL SIGNATURE Waldo B. Meyer M.D. Mt Rainier Md. PHYSICIAN'S NAME (Type) Dr. Meyer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.			24a. REC'D BY REGISTRAR DATE Aug 2 1958		24b. REGISTRAR'S SIGNATURE Alfred		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

CERTIFICATE OF DEATH

1900

FILE NO.

REGISTRATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF DECEASED

NAME OF WIFE

NAME OF HUSBAND

NAME OF CHILD

NAME OF SISTER

NAME OF BROTHER

NAME OF NEPHEW

NAME OF Niece

NAME OF GRANDCHILD

NAME OF GRANDPARENT

NAME OF GREAT-GRANDCHILD

NAME OF GREAT-GRANDPARENT

NAME OF GREAT-GRANDNiece

NAME OF GREAT-GRANDNephew

NAME OF GREAT-GRANDSISTER

NAME OF GREAT-GRANDBROTHER

NAME OF GREAT-GRANDMOTHER

NAME OF GREAT-GRANDFATHER

NAME OF GREAT-GRANDDAUGHTER

NAME OF GREAT-GRANDSON

NAME OF GREAT-GRANDNiece

NAME OF GREAT-GRANDNephew

NAME OF GREAT-GRANDSISTER

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NAME OF GREAT-GRANDMOTHER

NAME OF GREAT-GRANDFATHER

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NAME OF GREAT-GRANDSON

NAME OF GREAT-GRANDNiece

NAME OF GREAT-GRANDNephew

NAME OF GREAT-GRANDSISTER

NAME OF GREAT-GRANDBROTHER

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Wade</u>		
b. CITY OR TOWN <u>Silesia</u> (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN <u>Miami</u> (If outside corporate limits, write RURAL and give nearest town)		
c. LENGTH OF STAY IN 1b. <u>33</u>			d. STREET ADDRESS <u>2351-1st 26th Ave</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7500 Blackington Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Saul</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1958</u>		
5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Dec 6, 1921</u>		
9. AGE (In years last birthday) <u>36</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		
11. BIRTHPLACE (State or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Isaac Mendlin</u>			14. MOTHER'S MAIDEN NAME <u>Fannie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>?</u>		
17. INFORMANT <u>St Elizabeth Hospital Records</u>			Address <u>DC</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat prostration</u> 931.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Convulsive seizure with</u> DUE TO (c) <u>homicidal cause</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a convulsive seizure and lay out in the direct sun rays.</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had a convulsive seizure and lay out in the direct sun rays.</u>		
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lexington Road</u>	
20f. (City or town) <u>Silesia</u>		20g. (County) <u>P.G.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Aug 22, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE Mem. Chapel</u>	
22d. LOCATION (City, town, or county) <u>N.Y. City</u>		22e. (State) <u>N.Y.</u>		22f. (City, town, or county) <u>N.Y. City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gooding Funeral Home</u>			24. REC'D BY REGISTRAR <u>4217 9th</u>		
24a. DATE <u>AUG 25 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TOP STATE
HEAL H-DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9442

[Faint, mostly illegible handwritten text and stamps are visible throughout the form, including what appears to be a date '1911' in the top left corner.]

[The form contains several checkboxes and fields for medical data, many of which are obscured by the faint handwriting.]

[A large, stylized signature or stamp is visible in the lower right quadrant of the form.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09412

9404

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Monsheimer		4. DATE OF DEATH Month Day Year Aug 21 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer - Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Monsheimer		14. MOTHER'S MAIDEN NAME Bertha Lowenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harold Levy Address 5725 29th Ave., Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 10 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 19 58 to Aug 21 19 58 , that I last saw the deceased alive on Aug 21 19 58 , and that death occurred at 6:07 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donati Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 8/21/58	
PHYSICIAN'S NAME (Type) NORMAN DONATI COMEAU		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 24, 1958	22c. NAME OF CEMETERY OR CREMATORY Baron Hirsch Cemetery	22d. LOCATION (City, town, or county) (State) Staten Island New York
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR AUG 25 58 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 3. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G233 8-27-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

09413

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges general</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Park,</u> d. STREET ADDRESS <u>8104 Penn Brook Pl.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie</u> <u>Monteith</u> 4. DATE OF DEATH Month Day Year <u>August 11,</u> <u>1</u> 19 <u>58</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-29-78</u> 9. AGE (In years lost birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinoise</u> 11. BIRTHPLACE (State or foreign country) <u>Illinoise</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOHN WILEMAN</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH FIELDS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ruth Hicker</u> Address <u>5804 Penbrook Place</u> <u>Palmer Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mesenteric Thrombosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from _____, 19____, to <u>August 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 11</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Frederick Hartsock</u> M.D. <u>1835 Ege St. N. W. 8-12-58</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Frederick Hartsock</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Aug 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue. Rapids</u> 22d. LOCATION (City, town, or county) (State) <u>Blue. Rapids Kas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Jones</u> ADDRESS <u>300-4th St NE Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

3015

File No. 104

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		Home		Dr. J. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09414

Reg. Dist. No.

9406

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. STREET ADDRESS 4925 Wheeler Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maude Gertrude Moore		4. DATE OF DEATH August 29 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/84
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4 Hours 1 Min. 58	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
12. BIRTHPLACE (State or foreign country) District of Columbia		13. CITIZEN OF WHAT COUNTRY U. S. A.	
14. FATHER'S NAME Joseph W. Fillius		15. MOTHER'S MAIDEN NAME Mary A. Smith	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Gilbert F. Moore, Same as # 2		19. ADDRESS Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the left hip. (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor in home	
20c. TIME OF INJURY Month, Day, Year 11:00 XXX 8/26 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Oxon Hill P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 30, 1958	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 1-58	
22c. NAME OF CEMETERY OR CREMATORY St Barnabas		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros - 1661 - 94 Hope Rd		24a. REC'D BY REGISTRAR SEP 2 58	
24b. REGISTRAR'S SIGNATURE Wahoe			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

9447

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.R. Brandywine, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PRISCILLA Middle MOORE Last MOORE		4. DATE OF DEATH Month August Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1863
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during usual life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Pr. Geo. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME 7		14. MOTHER'S MAIDEN NAME Clanice Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ada Neale, Brandywine, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old age. 422.2 DUE TO Chronic Hypocretal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) worn out DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour _____ p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from June 22, 1954 to Aug 4, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Vahel M. Seron M.D.		ADDRESS (Street, city or town, state) Agassess Md DATE SIGNED 8/5/58	
PHYSICIAN'S NAME (Type) VAHEH M. SERON MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Asbury M.E.	22d. LOCATION (City, town, or county) (State) Brandywine, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR Aug 12 1958		24b. REGISTRAR'S SIGNATURE Arthur Shroyer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

9448

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Hgts.		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5506 Emerson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Louise Last Morris		4. DATE OF DEATH Month August Day 16 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1907
9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY A.F.C. Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Adam		14. MOTHER'S MAIDEN NAME Ida Kling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 165011043	
17. INFORMANT John P. Morris		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Ca to brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno carcinoma of breast DUE TO (c) 3 months 3 years			INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 58 to 8-16 , 19 58 that I last saw the deceased alive on 8-16 , 19 58 , and that death occurred at 6 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3717-38th Ave College City, Md 8/16/58			
ACTUAL SIGNATURE George Hageage M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Philadelphia, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS 4739 Balto. Ave. Hyattsville, Md.	
24a. REC'D BY REGISTRAR AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1942

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Occupation		Cause of Death	
Manner of Death		Signature of Physician	
Signature of Informant		Signature of Registrar	
Date of Statement		Place of Statement	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9449 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09417

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b 55 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Burch Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Jarboe Mudd		4. DATE OF DEATH August 9 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Bernard Albert Mudd		14. MOTHER'S MAIDEN NAME Frances Edith Middleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT James Lee Mudd Sr., Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED August 9, 1958	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/12/58	22c. NAME OF CEMETERY OR CREMATORY Mt Carmel	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt & Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE AUG 13 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Haus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

DEATH CERTIFICATE

1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT AS TO THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL ISSUE A COPY TO THE NEXT OF KIN OR TO THE PERSON CHARGED WITH THE BURIAL OF THE DECEASED. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES ALBERT		M		45		JAN 15 1880		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CARPENTER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1920		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESSES		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. ALBERT		J. ALBERT		J. ALBERT		J. ALBERT		J. ALBERT	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1920		JAN 20 1920		JAN 20 1920		JAN 20 1920		JAN 20 1920	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9363

CERTIFICATE OF DEATH

Reg. Dist. No.

09418

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
c. LENGTH OF STAY IN 1b 5 yrs.		d. STREET ADDRESS 4222 - 31 st. Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4222 - 31 st. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susie E. Mullinix		4. DATE OF DEATH Month Day Year 8 - 8 - 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1879
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work own home		11. BIRTHPLACE (State or foreign country) Washington DC	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Striker	
14. MOTHER'S MAIDEN NAME Annie White		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		17. INFORMANT Ruth Mc Pherson Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6 , 19 47 , to 8/8 , 19 57 , that I last saw the deceased alive on 8-3 , 19 58 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Earl W. Graeff M.D. 2716 Kirkwood Pl. W. Hyattsville ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) EARL W. GRAEFF MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Mt. Rainier, Md		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

9450

CERTIFICATE OF DEATH

Reg. Dist. No.

09419

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN IB 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
				d. STREET ADDRESS 36 W. St., N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle W. Last Myers				4. DATE OF DEATH Month 8 Day 7 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/8/93	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Henry Myers				14. MOTHER'S MAIDEN NAME Mary Nee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1917 - 1918				16. SOCIAL SECURITY NO. 577-09-4949			
17. INFORMANT Decedent				Address -			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day 12 yrs.,
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/25 , 19 58 , to 8/7 , 19 58 , that I last saw the deceased alive on 8/7 , 19 58 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss				ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 8/7/58			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE T. F. Costello				ADDRESS 1722 - N. Capital		24a. REC'D BY REGISTRAR 12 1958	
				Wash. D. C.		24b. REGISTRAR'S SIGNATURE Arthur L. Kravitz	

CERTIFICATE OF DEATH

54 50

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. CAUSE OF DEATH [Illegible]</p>	
<p>9. MANNER OF DEATH [Illegible]</p>		<p>10. DATE OF DEATH [Illegible]</p>	
<p>11. PLACE OF DEATH [Illegible]</p>		<p>12. SIGNATURE OF PHYSICIAN [Illegible Signature]</p>	
<p>13. SIGNATURE OF REGISTRAR [Illegible Signature]</p>		<p>14. SIGNATURE OF WITNESS [Illegible Signature]</p>	

THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, HAS RECEIVED THE ABOVE CERTIFICATE OF DEATH, AND THE SAME IS HEREBY FILED FOR RECORD.

WITNESSED MY HAND AND SEAL OF OFFICE, THIS [Illegible] DAY OF [Illegible] 19[Illegible].

REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

09420

9451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADDELPHI				c. LENGTH OF STAY IN 1b 3 years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Adelphi	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2002 SARANAC ST.				d. STREET ADDRESS 2002 SARANAC ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES Elizabeth NEWMAN				4. DATE OF DEATH Month Day Year AUG. 23 1958			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 20, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ANDREW PEDERSEN				14. MOTHER'S MAIDEN NAME LOUISE HUBNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT Address Raymond Newman 2002 Saranac St Adelphi Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cystadenocarcinoma ovaries 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958 to AUG. 23, 1958 , that I last saw the deceased alive on AUG. 23, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6216 N.H. Ave NE WASHINGTON D.C. DATE SIGNED 8/23/58							
ACTUAL SIGNATURE William F. Simpson M.D.				PHYSICIAN'S NAME (Type) WILLIAM F SIMPSON WASHINGTON D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Warren Taltrow ADDRESS 3603 - 14th St. NW WASH DC				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9451

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 10-1-50

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. PLACE OF BIRTH NEW YORK	
5. DATE OF DEATH 10-15-50		6. TIME OF DEATH 10:30 AM		7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE	
9. DISEASE OR INJURY HEART DISEASE		10. MANNER OF DEATH NATURAL		11. SIGNATURE OF PHYSICIAN J. J. BROWN		12. SIGNATURE OF REGISTRAR J. J. BROWN	
13. SIGNATURE OF DECEASED J. J. BROWN		14. SIGNATURE OF WITNESSES J. J. BROWN		15. SIGNATURE OF DECEASED J. J. BROWN		16. SIGNATURE OF WITNESSES J. J. BROWN	
17. SIGNATURE OF DECEASED J. J. BROWN		18. SIGNATURE OF WITNESSES J. J. BROWN		19. SIGNATURE OF DECEASED J. J. BROWN		20. SIGNATURE OF WITNESSES J. J. BROWN	
21. SIGNATURE OF DECEASED J. J. BROWN		22. SIGNATURE OF WITNESSES J. J. BROWN		23. SIGNATURE OF DECEASED J. J. BROWN		24. SIGNATURE OF WITNESSES J. J. BROWN	
25. SIGNATURE OF DECEASED J. J. BROWN		26. SIGNATURE OF WITNESSES J. J. BROWN		27. SIGNATURE OF DECEASED J. J. BROWN		28. SIGNATURE OF WITNESSES J. J. BROWN	
29. SIGNATURE OF DECEASED J. J. BROWN		30. SIGNATURE OF WITNESSES J. J. BROWN		31. SIGNATURE OF DECEASED J. J. BROWN		32. SIGNATURE OF WITNESSES J. J. BROWN	
33. SIGNATURE OF DECEASED J. J. BROWN		34. SIGNATURE OF WITNESSES J. J. BROWN		35. SIGNATURE OF DECEASED J. J. BROWN		36. SIGNATURE OF WITNESSES J. J. BROWN	
37. SIGNATURE OF DECEASED J. J. BROWN		38. SIGNATURE OF WITNESSES J. J. BROWN		39. SIGNATURE OF DECEASED J. J. BROWN		40. SIGNATURE OF WITNESSES J. J. BROWN	
41. SIGNATURE OF DECEASED J. J. BROWN		42. SIGNATURE OF WITNESSES J. J. BROWN		43. SIGNATURE OF DECEASED J. J. BROWN		44. SIGNATURE OF WITNESSES J. J. BROWN	
45. SIGNATURE OF DECEASED J. J. BROWN		46. SIGNATURE OF WITNESSES J. J. BROWN		47. SIGNATURE OF DECEASED J. J. BROWN		48. SIGNATURE OF WITNESSES J. J. BROWN	
49. SIGNATURE OF DECEASED J. J. BROWN		50. SIGNATURE OF WITNESSES J. J. BROWN		51. SIGNATURE OF DECEASED J. J. BROWN		52. SIGNATURE OF WITNESSES J. J. BROWN	
53. SIGNATURE OF DECEASED J. J. BROWN		54. SIGNATURE OF WITNESSES J. J. BROWN		55. SIGNATURE OF DECEASED J. J. BROWN		56. SIGNATURE OF WITNESSES J. J. BROWN	
57. SIGNATURE OF DECEASED J. J. BROWN		58. SIGNATURE OF WITNESSES J. J. BROWN		59. SIGNATURE OF DECEASED J. J. BROWN		60. SIGNATURE OF WITNESSES J. J. BROWN	
61. SIGNATURE OF DECEASED J. J. BROWN		62. SIGNATURE OF WITNESSES J. J. BROWN		63. SIGNATURE OF DECEASED J. J. BROWN		64. SIGNATURE OF WITNESSES J. J. BROWN	
65. SIGNATURE OF DECEASED J. J. BROWN		66. SIGNATURE OF WITNESSES J. J. BROWN		67. SIGNATURE OF DECEASED J. J. BROWN		68. SIGNATURE OF WITNESSES J. J. BROWN	
69. SIGNATURE OF DECEASED J. J. BROWN		70. SIGNATURE OF WITNESSES J. J. BROWN		71. SIGNATURE OF DECEASED J. J. BROWN		72. SIGNATURE OF WITNESSES J. J. BROWN	
73. SIGNATURE OF DECEASED J. J. BROWN		74. SIGNATURE OF WITNESSES J. J. BROWN		75. SIGNATURE OF DECEASED J. J. BROWN		76. SIGNATURE OF WITNESSES J. J. BROWN	
77. SIGNATURE OF DECEASED J. J. BROWN		78. SIGNATURE OF WITNESSES J. J. BROWN		79. SIGNATURE OF DECEASED J. J. BROWN		80. SIGNATURE OF WITNESSES J. J. BROWN	
81. SIGNATURE OF DECEASED J. J. BROWN		82. SIGNATURE OF WITNESSES J. J. BROWN		83. SIGNATURE OF DECEASED J. J. BROWN		84. SIGNATURE OF WITNESSES J. J. BROWN	
85. SIGNATURE OF DECEASED J. J. BROWN		86. SIGNATURE OF WITNESSES J. J. BROWN		87. SIGNATURE OF DECEASED J. J. BROWN		88. SIGNATURE OF WITNESSES J. J. BROWN	
89. SIGNATURE OF DECEASED J. J. BROWN		90. SIGNATURE OF WITNESSES J. J. BROWN		91. SIGNATURE OF DECEASED J. J. BROWN		92. SIGNATURE OF WITNESSES J. J. BROWN	
93. SIGNATURE OF DECEASED J. J. BROWN		94. SIGNATURE OF WITNESSES J. J. BROWN		95. SIGNATURE OF DECEASED J. J. BROWN		96. SIGNATURE OF WITNESSES J. J. BROWN	
97. SIGNATURE OF DECEASED J. J. BROWN		98. SIGNATURE OF WITNESSES J. J. BROWN		99. SIGNATURE OF DECEASED J. J. BROWN		100. SIGNATURE OF WITNESSES J. J. BROWN	

9407

011-04

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1907

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>		SEX <i>M</i>		RACE <i>W</i>	
DATE OF DEATH <i>Jan 15 1907</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Boston</i>		COUNTY <i>Suffolk</i>	
OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		MEDICAL ATTENDANT <i>Dr. J. B. Smith</i>	
SIGNATURE OF DECEASED <i>John J. Smith</i>		SIGNATURE OF NEXT OF KIN <i>John J. Smith</i>		SIGNATURE OF MEDICAL ATTENDANT <i>Dr. J. B. Smith</i>		SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
DATE OF SIGNATURE <i>Jan 15 1907</i>		DATE OF SIGNATURE <i>Jan 15 1907</i>		DATE OF SIGNATURE <i>Jan 15 1907</i>		DATE OF SIGNATURE <i>Jan 15 1907</i>	

CERTIFICATE OF DEATH

9408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> <u>L</u> <u>Norris</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 April 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walterman</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H Norris</u>				14. MOTHER'S MAIDEN NAME <u>Jane Ann Cheseltine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>578-54-1502</u>			
17. INFORMANT <u>Hospital Records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cerebral Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>26 July</u> , 19 <u>58</u> , to <u>1 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>31 July</u> , 19 <u>58</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon R Gallin MD</u> M.D.				ADDRESS (Street, city or town, state) <u>7206 Colwell Rd Md.</u> DATE SIGNED <u>W. Hejaffarilla Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Leon Gallin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/4/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>				22d. LOCATION (City, town, or county) (State) <u>Bethwood Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Clark Mattingley</u> ADDRESS <u>Lanhamtown Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Hejaffarilla</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon to page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. PLACE OF DEATH

7. DATE

8. TIME

9. CAUSE OF DEATH

10. SIGNATURE

11. NAME OF DECEASED

12. NAME OF DECEASED

13. NAME OF DECEASED

14. NAME OF DECEASED

15. NAME OF DECEASED

16. NAME OF DECEASED

17. NAME OF DECEASED

18. NAME OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 8 & 10, Film G-233 8/26/58.cac.
9409
CERTIFICATE OF DEATH

09423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Warren Middle Norris Last Norris				4. DATE OF DEATH Month August Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/98 3/2/1889		9. AGE (In years lost birthday) 69 yrs.		10. BIRTHPLACE (State or foreign country) United States
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesmen Machinist				10b. KIND OF BUSINESS OR INDUSTRY Wash., D.C. Naval Gun Contracting Factory Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James S. Norris				14. MOTHER'S MAIDEN NAME Alice E. Tipton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Laura Norris 8529 58 Ave Berwyn Heights	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-Sclerotic Disease DUE TO 5 years (c)							INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August 5, 1958 , to August 16, 1958 , that I last saw the deceased alive on August 16, 1958 , and that death occurred at 8:35AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles C. Hageage				ADDRESS (Street, city or town, state) 3308 Perry St. Mt. Rainier, Md. DATE SIGNED 8/16/58			
PHYSICIAN'S NAME (Type) Dr. Charles Hageage							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Aug. 19, 1958		Cedar Hill		Southland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee ADDRESS Wash. D. C.				24a. REC'D BY REGISTRAR DATE AUG 19 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

8408

THE DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

AGE

DATE OF MARRIAGE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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9410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper marlboro d. STREET ADDRESS Box 256 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Ann La Rue Owens			4. DATE OF DEATH Month Day Year August 7 1958		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-26		9. AGE (In years last birthday) yrs. 31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry D. Ayers		14. MOTHER'S MAIDEN NAME Ida Buford		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband-Horace Owens-Upper Marlboro, M Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from July 28 , 19 58 , to 8-7 , 19 58 , that I last saw the deceased alive on 8-7 , 19 58 , and that death occurred at 6:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE R.B. Sasser M.D.					
PHYSICIAN'S NAME (Type) Dr. R.B. Sasser					
22a. BURIAL, CREMATION, REMOVAL (Specify) XXXX		22b. DATE THEREOF 8-12-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington, Va.		24a. REC'D BY REGISTRAR Arthur L. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Rollins		ADDRESS 4339 Hunt Pl., N.W.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Any death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

Reg. No. 12

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9411

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>K.</u> Last <u>Petty</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/16/84</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>		IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>Charles Seanderlich</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Heidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>			
17. INFORMANT <u>Charles E Petty</u>				Address <u>4513 Oliver St. Riverdale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Age carcinoma</u> DUE TO <u>ovarian cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1750</u> DUE TO (c) <u>14</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 26</u> , 19 <u>58</u> , to <u>August 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 30</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>T. Bergeman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. T. Bergeman</u> M.D.				Hyattsville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>9-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	
22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Darch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1911

TAMM

Volume

1. Name of deceased: John T. Tamm

2. Sex: Male

3. Age: 40

4. Date of death: April 10, 1911

5. Place of death: Home

6. Cause of death: Heart Disease

7. Signature of physician: Dr. J. T. Tamm

8. Signature of registrar: John T. Tamm

9. Date of registration: April 10, 1911

10. Place of registration: Home

11. Signature of registrar: John T. Tamm

12. Date of registration: April 10, 1911

13. Place of registration: Home

14. Signature of registrar: John T. Tamm

15. Date of registration: April 10, 1911

16. Place of registration: Home

17. Signature of registrar: John T. Tamm

18. Date of registration: April 10, 1911

19. Place of registration: Home

20. Signature of registrar: John T. Tamm

21. Date of registration: April 10, 1911

22. Place of registration: Home

23. Signature of registrar: John T. Tamm

24. Date of registration: April 10, 1911

25. Place of registration: Home

26. Signature of registrar: John T. Tamm

27. Date of registration: April 10, 1911

28. Place of registration: Home

29. Signature of registrar: John T. Tamm

30. Date of registration: April 10, 1911

31. Place of registration: Home

32. Signature of registrar: John T. Tamm

33. Date of registration: April 10, 1911

34. Place of registration: Home

35. Signature of registrar: John T. Tamm

36. Date of registration: April 10, 1911

37. Place of registration: Home

38. Signature of registrar: John T. Tamm

39. Date of registration: April 10, 1911

40. Place of registration: Home

41. Signature of registrar: John T. Tamm

42. Date of registration: April 10, 1911

43. Place of registration: Home

44. Signature of registrar: John T. Tamm

45. Date of registration: April 10, 1911

46. Place of registration: Home

47. Signature of registrar: John T. Tamm

48. Date of registration: April 10, 1911

49. Place of registration: Home

50. Signature of registrar: John T. Tamm

51. Date of registration: April 10, 1911

52. Place of registration: Home

53. Signature of registrar: John T. Tamm

54. Date of registration: April 10, 1911

55. Place of registration: Home

56. Signature of registrar: John T. Tamm

57. Date of registration: April 10, 1911

58. Place of registration: Home

59. Signature of registrar: John T. Tamm

60. Date of registration: April 10, 1911

61. Place of registration: Home

62. Signature of registrar: John T. Tamm

63. Date of registration: April 10, 1911

64. Place of registration: Home

65. Signature of registrar: John T. Tamm

66. Date of registration: April 10, 1911

67. Place of registration: Home

68. Signature of registrar: John T. Tamm

69. Date of registration: April 10, 1911

70. Place of registration: Home

71. Signature of registrar: John T. Tamm

72. Date of registration: April 10, 1911

73. Place of registration: Home

74. Signature of registrar: John T. Tamm

75. Date of registration: April 10, 1911

76. Place of registration: Home

77. Signature of registrar: John T. Tamm

78. Date of registration: April 10, 1911

79. Place of registration: Home

80. Signature of registrar: John T. Tamm

81. Date of registration: April 10, 1911

82. Place of registration: Home

83. Signature of registrar: John T. Tamm

84. Date of registration: April 10, 1911

85. Place of registration: Home

86. Signature of registrar: John T. Tamm

87. Date of registration: April 10, 1911

88. Place of registration: Home

89. Signature of registrar: John T. Tamm

90. Date of registration: April 10, 1911

91. Place of registration: Home

92. Signature of registrar: John T. Tamm

93. Date of registration: April 10, 1911

94. Place of registration: Home

95. Signature of registrar: John T. Tamm

96. Date of registration: April 10, 1911

97. Place of registration: Home

98. Signature of registrar: John T. Tamm

99. Date of registration: April 10, 1911

100. Place of registration: Home

9412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook Acres</u>		d. STREET ADDRESS <u>9405 Tuckerman St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Pinkos</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-3-1919</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin Assistant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Treasury Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Akron, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Pinkos</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Chikorski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>299-03-5489</u>		17. INFORMANT <u>Eleanor M. Pinkos</u> address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulm. Cong. & edema</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple cerebral splenic & renal infarct</u> DUE TO (c) <u>Rheumatic heart disease.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>August 7, 19 58</u> to <u>Aug 14, 19 58</u> that I last saw the deceased alive on <u>Aug. 13, 19 58</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D. <u>4713 Keeney Rd</u>				DATE SIGNED <u>8/14/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wolcott Etienne</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kelly's Funeral Home</u>				ADDRESS <u>W. L. Etienne</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH 1/8/30

2030

1-3-30

Chlorine

poisoning

large quantity

of chlorine

gas

was used

to kill

the rats

in the

basement

of the

house

10000

9364

CERTIFICATE OF DEATH

09427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RANIER MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RANIER MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3105 QUEENS CHAPEL RD</u>		d. STREET ADDRESS <u>3105 QUEENS CHAPEL RD</u>	
3. NAME OF DECEASED (Type or print) <u>NETTIE IRINE RAPER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CLINTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES LUSBY</u>		14. MOTHER'S MAIDEN NAME <u>LUCKETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM H. RAPER JR.</u>		Address <u>4500 30th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXHAUSTION CARDIAC FAILURE</u> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS - TOXEMIA</u> DUE TO (c) <u>PRIMARY CA. urinary bladder</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 5</u> 19 <u>57</u> to <u>AUG 14</u> 19 <u>58</u> that I last saw the deceased alive on <u>AUG 14 1958</u> and that death occurred at <u>11:50 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Harrington</u> M.D.		ADDRESS (Street, city or town, state) <u>3810 7th NE</u>	
PHYSICIAN'S NAME (Type) <u>John F. Harrington</u>		DATE SIGNED <u>8/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 18 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELLENWOOD</u>
22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm LEE</u>		ADDRESS <u>300 H ST NE</u>	
24a. REC'D BY REGISTRAR <u>AUG 18 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Edwin S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH RECORD

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 15, 1925</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. Smith</i></p>	
<p>8. Signature of registrar: <i>John Doe</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of page 3 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09428

9365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b years 16		d. STREET ADDRESS 1 3716-36 th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3716-36 th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes E. Redmond		4. DATE OF DEATH Month 8 Day 2nd Year 19 68	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/77
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John McGowne		14. MOTHER'S MAIDEN NAME Catherine Mc Intire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dorothy Redmond		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 General Visceral Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2600 (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 56, to Aug 19 58, that I last saw the deceased alive on 3/1 19 58, and that death occurred at 3:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo Jr.		ADDRESS (Street, city or town, state) 1840 Michigan Ave NE DC	
PHYSICIAN'S NAME (Type) FRANK M. TROZZO JR		DATE SIGNED 8/2/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Oliver		22d. LOCATION (City, town, or county) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home		24. REC'D BY REGISTRAR DATE AUG 6 '58	
ADDRESS Mt. Rainier Md.		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

Reg. No. 44

DECEASED Name <i>John A. Smith</i> Sex <i>Male</i> Date of Birth <i>Jan 15 1885</i> Place of Birth <i>St. Louis, Mo.</i> Usual Residence <i>1234 N. Broadway, Baltimore, Md.</i> Date of Death <i>Dec 10 1945</i> Place of Death <i>Home</i> Cause of Death <i>Heart Disease</i> Manner of Death <i>Natural</i> Physician <i>Dr. J. H. Jones</i> Burial Place <i>Greenwood Cemetery</i> Registrar <i>John A. Smith</i> Signature <i>[Signature]</i> Date <i>Dec 15 1945</i>		COUNTY OF <i>Baltimore</i> CITY OF <i>Baltimore</i> DISTRICT OF <i>North</i> WARD OF <i>1st</i> BLOCK OF <i>1234</i> HOUSE NO. <i>1234</i> STREET <i>N. Broadway</i> CITY <i>Baltimore</i> STATE <i>Md.</i> ZIP CODE <i>21201</i>
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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. If a burial-transit permit is required, the permit should be used as a burial-transit permit, and in any event, within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) County Service Building		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City 69X-3	
3. NAME OF DECEASED (Type or print) Nello A. Reynolds		d. STREET ADDRESS 154 W. 141st Street	
5. SEX Male		6. COLOR OR RACE colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-22	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXX Soldier		12. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13. BIRTHPLACE (State or foreign country) Bermuda, West Indies		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Samuel G. Reynolds		16. MOTHER'S MAIDEN NAME Mary Wood	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		18. SOCIAL SECURITY NO. Currently	
19. INFORMANT U.S. Army Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hanging DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Suicidal hanging		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4.00 a.m. 8-9- 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> Not of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jail		20f. (City or town) Hyattsville, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Aug. 9, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-58	
22c. NAME OF CEMETERY OR CREMATORY L. I. Nat'l. Cemetery		22d. LOCATION (City, town, or county) Farmdale, L. I., N. Y. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3001 15th St., N. E.		24a. REC'D BY REGISTRAR AUG 13 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
9360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. HOME		2. PLACE OF DEATH b. OTHER	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. DATE OF BIRTH	
7. OCCUPATION		8. CAUSE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF NEXT OF KIN		14. SIGNATURE OF PHYSICIAN	
15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF BURIAL OFFICIAL	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CORONER	
19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF DISTRICT ATTORNEY		22. SIGNATURE OF SHERIFF	
23. SIGNATURE OF CLERK		24. SIGNATURE OF RECORDER	
25. SIGNATURE OF ARCHIVIST		26. SIGNATURE OF INDEXER	
27. SIGNATURE OF ASSISTANT CLERK		28. SIGNATURE OF DEPUTY CLERK	
29. SIGNATURE OF DEPUTY ARCHIVIST		30. SIGNATURE OF DEPUTY INDEXER	
31. SIGNATURE OF DEPUTY RECORDER		32. SIGNATURE OF DEPUTY CLERK	
33. SIGNATURE OF DEPUTY ARCHIVIST		34. SIGNATURE OF DEPUTY INDEXER	
35. SIGNATURE OF DEPUTY RECORDER		36. SIGNATURE OF DEPUTY CLERK	
37. SIGNATURE OF DEPUTY ARCHIVIST		38. SIGNATURE OF DEPUTY INDEXER	
39. SIGNATURE OF DEPUTY RECORDER		40. SIGNATURE OF DEPUTY CLERK	
41. SIGNATURE OF DEPUTY ARCHIVIST		42. SIGNATURE OF DEPUTY INDEXER	
43. SIGNATURE OF DEPUTY RECORDER		44. SIGNATURE OF DEPUTY CLERK	
45. SIGNATURE OF DEPUTY ARCHIVIST		46. SIGNATURE OF DEPUTY INDEXER	
47. SIGNATURE OF DEPUTY RECORDER		48. SIGNATURE OF DEPUTY CLERK	
49. SIGNATURE OF DEPUTY ARCHIVIST		50. SIGNATURE OF DEPUTY INDEXER	
51. SIGNATURE OF DEPUTY RECORDER		52. SIGNATURE OF DEPUTY CLERK	
53. SIGNATURE OF DEPUTY ARCHIVIST		54. SIGNATURE OF DEPUTY INDEXER	
55. SIGNATURE OF DEPUTY RECORDER		56. SIGNATURE OF DEPUTY CLERK	
57. SIGNATURE OF DEPUTY ARCHIVIST		58. SIGNATURE OF DEPUTY INDEXER	
59. SIGNATURE OF DEPUTY RECORDER		60. SIGNATURE OF DEPUTY CLERK	
61. SIGNATURE OF DEPUTY ARCHIVIST		62. SIGNATURE OF DEPUTY INDEXER	
63. SIGNATURE OF DEPUTY RECORDER		64. SIGNATURE OF DEPUTY CLERK	
65. SIGNATURE OF DEPUTY ARCHIVIST		66. SIGNATURE OF DEPUTY INDEXER	
67. SIGNATURE OF DEPUTY RECORDER		68. SIGNATURE OF DEPUTY CLERK	
69. SIGNATURE OF DEPUTY ARCHIVIST		70. SIGNATURE OF DEPUTY INDEXER	
71. SIGNATURE OF DEPUTY RECORDER		72. SIGNATURE OF DEPUTY CLERK	
73. SIGNATURE OF DEPUTY ARCHIVIST		74. SIGNATURE OF DEPUTY INDEXER	
75. SIGNATURE OF DEPUTY RECORDER		76. SIGNATURE OF DEPUTY CLERK	
77. SIGNATURE OF DEPUTY ARCHIVIST		78. SIGNATURE OF DEPUTY INDEXER	
79. SIGNATURE OF DEPUTY RECORDER		80. SIGNATURE OF DEPUTY CLERK	
81. SIGNATURE OF DEPUTY ARCHIVIST		82. SIGNATURE OF DEPUTY INDEXER	
83. SIGNATURE OF DEPUTY RECORDER		84. SIGNATURE OF DEPUTY CLERK	
85. SIGNATURE OF DEPUTY ARCHIVIST		86. SIGNATURE OF DEPUTY INDEXER	
87. SIGNATURE OF DEPUTY RECORDER		88. SIGNATURE OF DEPUTY CLERK	
89. SIGNATURE OF DEPUTY ARCHIVIST		90. SIGNATURE OF DEPUTY INDEXER	
91. SIGNATURE OF DEPUTY RECORDER		92. SIGNATURE OF DEPUTY CLERK	
93. SIGNATURE OF DEPUTY ARCHIVIST		94. SIGNATURE OF DEPUTY INDEXER	
95. SIGNATURE OF DEPUTY RECORDER		96. SIGNATURE OF DEPUTY CLERK	
97. SIGNATURE OF DEPUTY ARCHIVIST		98. SIGNATURE OF DEPUTY INDEXER	
99. SIGNATURE OF DEPUTY RECORDER		100. SIGNATURE OF DEPUTY CLERK	

9452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Robey</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-72</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES King</u>		14. MOTHER'S MAIDEN NAME <u>Susan Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Mary I Wilburn</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Asthma - Coronary Arteriosclerosis</u> 2 yrs DUE TO (c) <u>General Arteriosclerosis</u> unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1</u> , 1958, to <u>Aug 21</u> , 1958, that I last saw the deceased alive on <u>Aug 21</u> , 1958, and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. P. P. Van Natta</u>		M.D. <u>PAUL P. VAN Natta</u>	
PHYSICIAN'S NAME (Type) <u>PAUL P. VAN Natta</u>		<u>Washington 28 Wc</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EPIPHANY CHURCH CEM</u>	22d. LOCATION (City, town, or county) (State) <u>FORESTVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>		ADDRESS <u>517-11th St SE.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09431

Reg. Dist. No.

9453

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T. B.		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				f. STREET ADDRESS Fort Foote Road			
3. NAME OF DECEASED (Type or print) First Joseph Middle Francis Last Robinson				4. DATE OF DEATH Month August Day 9 Year 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1916		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morton Robinson				14. MOTHER'S MAIDEN NAME Mary Agnes Sewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. 11		17. INFORMANT Address Mary Lillian Wilkerson, Waldorf, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Shot gun wound of the chest (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was shot while trying to set a house on fire					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8/9/ 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of home		20f. (City or town) T.B.	(County) P.G.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED August 9, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR AUG 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

James George's

1. 1.

James I.

James I.

Colored

Male

Labourer

Male

Maryland

James I.

James I. (son, white, 18)

Handcuffed and shack

Shot and wound of the chest

See shot with white light to see a house on fire

in yard of home

James I. 1898

August 9, 1928

Beaver 8/13/28 Arlington National Arlington, Va
The Hunt Farm, Hunt, Va

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09432

9413

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 1412 DePafield PLACE			
3. NAME OF DECEASED (Type or print) ROSE First ROSE Middle ROSE Last ROSE				4. DATE OF DEATH 8 - 11 - 1958 Month 8 Day 11 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct-10-1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pearl Stinger				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) VIENNA - AUSTRIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE TENZER				14. MOTHER'S MAIDEN NAME CHARLOTTE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 025-14-6956			
17. INFORMANT A Hosp. Records				Address LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 334 DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO and left Hemiplegia (c) and left Hemiplegia							
INTERVAL BETWEEN ONSET AND DEATH 2 days ago 14 yrs ago							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month, Day, Year 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-19- , 19 57 , to 8-11- , 19 58 , that I last saw the deceased alive on 8-11- , 19 58 , and that death occurred at 5:40 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer				DATE SIGNED 8-11-58			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				ADDRESS LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12-1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince George's Md	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash. DC				24a. REC'D BY REGISTRAR Arthur S. Kraus			
ADDRESS Wash. DC				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 12-1-28		PLACE OF BIRTH MOBILE, ALA.	
MARRIAGE MARRIED		DATE OF MARRIAGE 1-15-50		PLACE OF MARRIAGE MEMPHIS, TENN.	
OCCUPATION MEMBER, CONGRESS		DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENN.	
CAUSE OF DEATH HEART DISEASE		DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENN.	
MANNER OF DEATH NATURAL		DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENN.	
SIGNATURE OF DECEASED JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF WITNESS JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF CORONER JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF JURY JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF JUDGE JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF CLERK JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF NOTARY JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF DECEASED JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF WITNESS JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF CORONER JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF JURY JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF JUDGE JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF CLERK JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	
SIGNATURE OF NOTARY JAMES EARL RAY		DATE OF SIGNATURE 4-4-68		PLACE OF SIGNATURE MEMPHIS, TENN.	

THIS IS A COPY OF THE ORIGINAL RECORD OF DEATH, AS MAINTAINED BY THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 20b Film 233 9-9-58 ams
9454
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09433

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Colorado b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlboro, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Longmont 44X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB		d. STREET ADDRESS 523 8th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Peter Last Roth		4. DATE OF DEATH Month August Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 August 1938
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Jacob Roth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 523-48-9595	
17. INFORMANT Official Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple internal injuries, severe 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sitting next to driver. Car went off highway hitting tree.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1:20 PM Aug 27 1958		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Marlboro (County) Prince Georges (State) Md.	
21. I certify that I attended the deceased from DOA, 19, to, 19, that I last saw the deceased alive on, 19, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		USAF Hospital Andrews, Andrews AFB 27 Aug 58	
PHYSICIAN'S NAME (Type) ALFRED G. LEONARD, Capt USAF (MC)		Capt (MC) USAF	
22a. BURIAL, CREMATION, or other final disposition BURIAL		22b. DATE THEREOF 8-29-58	
22c. NAME OF CEMETERY OR CREMATORY GOLDEN GATE NATL CEM		22d. LOCATION (City, town, or county) (State) SAN FRANCISCO, CALIF	
23. FUNERAL DIRECTOR'S SIGNATURE W W CHAMBERS CO		24a. REC'D BY REGISTRAR AUG 29 58	
ADDRESS 1400 CHAPIN ST NW		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16			
c. LENGTH OF STAY IN 1b 2 days and 9 1/2 hr.				d. STREET ADDRESS 4012 37th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Mae Last Rowan				4. DATE OF DEATH Month August Day 24 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-88	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Thomas Parker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT William F. Rowan Address Mt Rainier, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 Year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from April 1952 to Aug 24, 1958 that I last saw the deceased alive on Aug 24, 1958 and that death occurred at 9:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Rowan				ADDRESS (Street, city or town, state) 3503 Penny St			
PHYSICIAN'S NAME (Type) Dr. Charles Hager				DATE SIGNED 8/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 27, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR AUG 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9455

CERTIFICATE OF DEATH

Reg. Dist. No.

09435

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS 1716- 22- Street S. E.	
3. NAME OF DECEASED (Type or print) ADELAIDE T. ROWLEY		4. DATE OF DEATH Month August Day 31st Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12th. 1877
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Taylor		14. MOTHER'S MAIDEN NAME Tabiatha Suttle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Clarence A. Rowley		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Rt Lung DUE TO 170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma right breast DUE TO (c) 6 1/2 months		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 15, 19 58 to August 31, 19 58 that I last saw the deceased alive on Aug 30, 19 58 , and that death occurred at 8 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert S. Gates		ADDRESS (Street, city or town, state) 815- East Cap. Street Washington, D.C.	
PHYSICIAN'S NAME (Type) HERBERT S. GATES		DATE SIGNED August 31st 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 3-58	22c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery	22d. LOCATION (City, town, or county) (State) West Moreland Co., Va.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DATE SEP 2 '58	
ADDRESS 1661 Good Hope Rd S E. Wash DC		24b. REGISTRAR'S SIGNATURE Charles L. Evans	

CERTIFICATE OF DEATH

9035

NAME OF DECEASED Frances Moore		SEX Female	
DATE OF BIRTH 18 June		PLACE OF BIRTH Baltimore, Maryland	
DATE OF DEATH 1910-02-20		PLACE OF DEATH Baltimore, Maryland	
TIME OF DEATH 10:00 AM		PLACE OF DEATH Baltimore, Maryland	
NAME OF DECEASED John Taylor		SEX Male	
DATE OF BIRTH 1910-02-20		PLACE OF BIRTH Baltimore, Maryland	
DATE OF DEATH 1910-02-20		PLACE OF DEATH Baltimore, Maryland	
TIME OF DEATH 10:00 AM		PLACE OF DEATH Baltimore, Maryland	
NAME OF DECEASED John Taylor		SEX Male	
DATE OF BIRTH 1910-02-20		PLACE OF BIRTH Baltimore, Maryland	
DATE OF DEATH 1910-02-20		PLACE OF DEATH Baltimore, Maryland	
TIME OF DEATH 10:00 AM		PLACE OF DEATH Baltimore, Maryland	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09436

Reg. Dist. No.

9456

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. LENGTH OF STAY IN 1b <u>30yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home - Bowie, Md</u>				d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Rucker</u> Middle <u>Rucker</u> Last			4. DATE OF DEATH Month <u>Aug.</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1902</u>		9. AGE (In years last birthday) <u>56 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>220-03857</u>			17. INFORMANT <u>Mary U. Rucker</u> Address <u>Bowie, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosis</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Cancer of bone</u> DUE TO (c) <u>Bronchiogenic Carcinoma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 mos</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Bowie</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Henry A. Wise, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug 26 '58</u>	
EXAMINER'S NAME (Type) <u>Henry A. Wise, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>8-29-58</u>		22b. DATE THEREOF <u>8-29-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem.</u>	
22d. LOCATION (City, town, or county) <u>Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stewart</u>		ADDRESS <u>30-H St. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1930

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1930

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Signature of Coroner: [Signature]

10. Signature of Registrar: [Signature]

11. Signature of Physician: [Signature]

12. Signature of Family: [Signature]

13. Signature of Burial Place: [Signature]

14. Signature of Other: [Signature]

15. Signature of Other: [Signature]

16. Signature of Other: [Signature]

17. Signature of Other: [Signature]

18. Signature of Other: [Signature]

19. Signature of Other: [Signature]

20. Signature of Other: [Signature]

21. Signature of Other: [Signature]

22. Signature of Other: [Signature]

23. Signature of Other: [Signature]

24. Signature of Other: [Signature]

25. Signature of Other: [Signature]

26. Signature of Other: [Signature]

27. Signature of Other: [Signature]

28. Signature of Other: [Signature]

29. Signature of Other: [Signature]

30. Signature of Other: [Signature]

31. Signature of Other: [Signature]

32. Signature of Other: [Signature]

33. Signature of Other: [Signature]

34. Signature of Other: [Signature]

35. Signature of Other: [Signature]

36. Signature of Other: [Signature]

37. Signature of Other: [Signature]

38. Signature of Other: [Signature]

39. Signature of Other: [Signature]

40. Signature of Other: [Signature]

41. Signature of Other: [Signature]

42. Signature of Other: [Signature]

43. Signature of Other: [Signature]

44. Signature of Other: [Signature]

45. Signature of Other: [Signature]

46. Signature of Other: [Signature]

47. Signature of Other: [Signature]

48. Signature of Other: [Signature]

49. Signature of Other: [Signature]

50. Signature of Other: [Signature]

51. Signature of Other: [Signature]

52. Signature of Other: [Signature]

53. Signature of Other: [Signature]

54. Signature of Other: [Signature]

55. Signature of Other: [Signature]

56. Signature of Other: [Signature]

57. Signature of Other: [Signature]

58. Signature of Other: [Signature]

59. Signature of Other: [Signature]

60. Signature of Other: [Signature]

61. Signature of Other: [Signature]

62. Signature of Other: [Signature]

63. Signature of Other: [Signature]

64. Signature of Other: [Signature]

65. Signature of Other: [Signature]

66. Signature of Other: [Signature]

67. Signature of Other: [Signature]

68. Signature of Other: [Signature]

69. Signature of Other: [Signature]

70. Signature of Other: [Signature]

71. Signature of Other: [Signature]

72. Signature of Other: [Signature]

73. Signature of Other: [Signature]

74. Signature of Other: [Signature]

75. Signature of Other: [Signature]

76. Signature of Other: [Signature]

77. Signature of Other: [Signature]

78. Signature of Other: [Signature]

79. Signature of Other: [Signature]

80. Signature of Other: [Signature]

81. Signature of Other: [Signature]

82. Signature of Other: [Signature]

83. Signature of Other: [Signature]

84. Signature of Other: [Signature]

85. Signature of Other: [Signature]

86. Signature of Other: [Signature]

87. Signature of Other: [Signature]

88. Signature of Other: [Signature]

89. Signature of Other: [Signature]

90. Signature of Other: [Signature]

91. Signature of Other: [Signature]

92. Signature of Other: [Signature]

93. Signature of Other: [Signature]

94. Signature of Other: [Signature]

95. Signature of Other: [Signature]

96. Signature of Other: [Signature]

97. Signature of Other: [Signature]

98. Signature of Other: [Signature]

99. Signature of Other: [Signature]

100. Signature of Other: [Signature]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Any of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9361

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington D C COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell Nursing Home		d. STREET ADDRESS 4929 First Street N W	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maria Middle Seidel Last		4. DATE OF DEATH Month August 22, Day 1958- Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1958
9. AGE (In years lost birthday) — yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. — 24 — —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marquis R Seidel		14. MOTHER'S MAIDEN NAME Norma Cipriano	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bell Nursing Home		Address Hyattsville Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cifer respiratory infection (c) Meningitis INTERVAL BETWEEN ONSET AND DEATH 2 days Birth on		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1958, to August 22, 1958, that I last saw the deceased alive on 8/22, 1958, and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theresa A. Christensen		M.D. College Park, Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED 8/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 23, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE C. L. Frank	

9VVVVVVVVXVV

CERTIFICATE OF DEATH

1981

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/1/45		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION None		8. MARITAL STATUS Single		9. EDUCATION High School	
10. DECEASED AT Baltimore, Maryland		11. DECEASED ON April 4, 1968		12. DECEASED AT Room 936, LBJ Library, Washington, D.C.	
13. CAUSE OF DEATH Gunshot wound to the chest		14. MANNER OF DEATH Suicide		15. PLACE OF DEATH Room 936, LBJ Library, Washington, D.C.	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]		21. SIGNATURE OF JUDGE [Signature]	

1. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

2. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

3. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

4. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

5. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

6. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

7. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

8. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

9. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

10. This is a true and correct copy of the original record of the death of JAMES EARL RAY, as recorded in the records of the Maryland State Department of Health, Baltimore, Maryland, on April 4, 1968.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09438

9415

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 West Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Joseph Last Sherwood, Jr.		4. DATE OF DEATH Month August Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Joseph Sherwood		14. MOTHER'S MAIDEN NAME Shirley Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Shirley Sherwood; same address as # 2.	
17. INFORMANT Shirley Sherwood; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO Conditions, if any, which gave rise to immediate cause (b) Smothering with a blanket (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Accidental smothering with a blanket in crib.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. Aug. 11 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) W. Hyattsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 11, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/58	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2077181XV5

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John T. Selway, M.D.		DATE OF DEATH August 11, 1918	
RESIDENCE Baltimore, Md.		PLACE OF DEATH Baltimore, Md.	
AGE 50 years		SEX Male	
RACE White		RELIGION Roman Catholic	
MARRIAGE Married		MANNER OF DEATH Accidental, smothering while a drunkard in car.	
OCCUPATION Physician		EDUCATION College	
PREVIOUS ILLNESS None		CAUSE OF DEATH Asphyxia	
MEDICAL HISTORY None		POST-MORTEM EXAMINATION None	
SIGNATURE OF PHYSICIAN John T. Selway, M.D.		SIGNATURE OF MEDICAL EXAMINER J. M. H. H. H.	
DATE August 11, 1918		PLACE Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09439

Reg. Dist. No.

9457

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ruatan 5626 Rowtan Street				d. STREET ADDRESS Ruatan 5626 Rowtan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Derma Ted Showard				4. DATE OF DEATH Month Aug. Day 8, Year 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-23		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Derma Ted Showard				14. MOTHER'S MAIDEN NAME Georgia Meers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 577-22-6036		17. INFORMANT Address Elsie Showard; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbonmonoxide poisoning (c) Conflagration in home							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in room of deceased. Cause unknown at this time.					
20c. TIME OF INJURY Month, Day, Year 2.30 o. m. 8-8-58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Berwyn Heights, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney		EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 8, k958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.- Arlington, Virginia		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				24a. REC'D BY REGISTRAR AUG 11 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• I was on the same mission? (1941)

George Higgins, Jr. Dec. 1894

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Y. H. Zeng, Y. M. Zeng

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G232 8-19-58 et.

09440

9362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 83X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		d. STREET ADDRESS <u>1737 Queens Lane</u> <u>Hyattsville, Md.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor O'NEILL Sloan</u>		4. DATE OF DEATH Month Day Year <u>August 10 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John O'NEILL</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES HANLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS M. O'NEILL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Circulatory Collapse</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>August 1958</u> , that I last saw the deceased alive on <u>Aug 7</u> , 19 <u>58</u> , and that death occurred at <u>3:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5415 Conn Ave NW Wash DC</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09441

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

3416

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg	
c. LENGTH OF STAY IN lb D.O.A.		d. STREET ADDRESS 5535 Volta Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert Leonard Snyder		4. DATE OF DEATH August 2, 19 58	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-96	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bradley Snyder		14. MOTHER'S MAIDEN NAME Bernice Kenard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leroy Snyder; 4205 74th Place,		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Occlusion (a), stating the underlying cause lost. (c) Cardiovascular renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 2, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 6 '58 DATE	
24b. REGISTRAR'S SIGNATURE W. H. ...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

FOR STATE
HEALTH DEPT.



STATE OF CALIFORNIA



UNITED STATES
DEPARTMENT OF HEALTH

MARYLAND STATEMENT OF HEALTH - BIRTH OR IN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE

PLACE

NAME

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9417

CERTIFICATE OF DEATH

09442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley</u>		c. LENGTH OF STAY IN 1b <u>16 Mount Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>3718-Wells Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>M.</u> Middle <u>SOULE</u> Last		4. DATE OF DEATH <u>August 16, 1958</u> Month <u>August</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1st/88</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Snaveley</u>		14. MOTHER'S MAIDEN NAME <u>McQuade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-77750</u>	
17. INFORMANT <u>Daughter</u> Address <u>above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15, 1958</u> to <u>Aug 16, 1958</u> , that I last saw the deceased alive on <u>Aug 16, 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Rosson MD</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u> DATE SIGNED <u>8/16/58</u>	
PHYSICIAN'S NAME (Type) <u>William D. Rosson MD</u>		<u>Bladensburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u> ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.S.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. LENGTH OF STAY IN TB <u>29 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4703 WEBSTER ST.</u>		d. STREET ADDRESS <u>4703 WEBSTER</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DELORES</u> Middle <u>Costello</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>B-22-1929</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>THOMAS TAVERN</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C. - Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE M. THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE M. SELBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>CORA WEBB GORNE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480X PNEUMONIA (Influenza)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>8-12-58-10-2-58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DERMATITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-9-1958</u> to <u>8-10-1958</u> , that I last saw the deceased alive on <u>8-9-1958</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Wm. W. Spiller</u> M.D. <u>4506 R.I. Ave. Brantwood Md.</u>		<u>Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Wm. W. Spiller</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swenden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kravitz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09444

9458

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>16 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2 Box 71 J</u>				d. STREET ADDRESS <u>1 RT 2 Box 71 J</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>EDWARD</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEPAINTER</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD EDWARD THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>HAILEY SELBY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-01-121</u>		17. INFORMANT Address <u>MARGARET THOMAS - WIFE - RT 2 Box 71 J</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL HEMORRHAGE</u> DUE TO <u>138.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SARCOIDOSIS, EXTENSIVE, TERMINAL</u> DUE TO <u>5 1/2 yrs.</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATOID ARTHRITIS FAR ADVANCED</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>					
20c. TIME OF INJURY Hour <u> </u> o. <u> </u> m. <u> </u> <u>NONE</u>		20d. INJURY OCCURRED While at work <u> </u> Not while at work <u> </u> <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>56</u> to <u>PRESENT</u> , that I last saw the deceased alive on <u>AUG. 3</u> , 19 <u>58</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave, Clinton, MD.</u> DATE SIGNED <u>8/3/58</u> ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. BRANCH AVE, CLINTON, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Whittingly</u>				ADDRESS <u>131-112 St Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>AUG 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Princedun</u>			

CERTIFICATE OF DEATH

1938

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES M. JONES		M		45		JAN 15 1893		BALTIMORE		MD		BALTIMORE		MD	
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY	
Carpenter		Married		High School		Roman Catholic		Heart Disease		Natural		Hospital		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		DAY		MONTH		YEAR		CITY	
JAN 25 1938		10:15 AM		10		15		25		JAN		1938		BALTIMORE	
PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
Hospital		BALTIMORE		MD		BALTIMORE		MD		BALTIMORE		MD		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		DAY		MONTH		YEAR		CITY	
JAN 25 1938		10:15 AM		10		15		25		JAN		1938		BALTIMORE	
PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
Hospital		BALTIMORE		MD		BALTIMORE		MD		BALTIMORE		MD		BALTIMORE	



RECEIVED
JAN 26 1938
BALTIMORE
STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09445

Reg. Dist. No.

9459

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leestrict Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leestrict Heights</u>		d. STREET ADDRESS <u>7209 Alpine Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie Massey Updike</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1896</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George William Rowles</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Massey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S Address <u>Reginald Byrd Updike, same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Aug 10, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Ee Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

1550

MEDICAL EXAMINER: CERTIFICATE OF DEATH

NASSAU COUNTY DEPT. OF HEALTH - BAYTOWN, N.Y.

NY 115

[Faint, mostly illegible handwritten text and printed form fields. Visible fragments include:]

NAME: *[illegible]*
AGE: *[illegible]*
SEX: *[illegible]*
DATE OF BIRTH: *[illegible]*
PLACE OF BIRTH: *[illegible]*
CAUSE OF DEATH: *[illegible]*
MANNER OF DEATH: *[illegible]*
SIGNATURE: *[illegible]*
DATE: *[illegible]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9419

CERTIFICATE OF DEATH

Reg. Dist. No.

09446

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad-Sacorda Conv. Home</u> <u>2601 Cheverly Ave.</u>				d. STREET ADDRESS <u>434 - 1st St., S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>A.</u> Last <u>Vammino</u>				4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Domenico Vammino</u>			14. MOTHER'S MAIDEN NAME <u>Concetta (unknown)</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>27 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/10</u> , 19 <u>58</u> , to <u>8/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>58</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 Cheverly Dr., Cheverly, Md.</u> DATE SIGNED <u>8/26/58</u>							
ACTUAL SIGNATURE <u>John Kehoe</u>			M.D. <u>3404 Cheverly Dr., Cheverly, Md.</u>				
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home</u>				ADDRESS <u>816 H St., N.E.,</u>		24a. REC'D BY REGISTRAR <u>Aug 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

CERTIFICATE OF DEATH

Page 101, 110

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1910</u></p>		<p>4. Place of birth: <u>London, England</u></p>	
<p>5. Date of death: <u>10-25-1960</u></p>		<p>6. Place of death: <u>London, England</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of Registrar: <u>[Signature]</u></p>		<p>10. Signature of Medical Officer: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10-26-1960</u></p>		<p>12. Place of registration: <u>London, England</u></p>	

5420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant, d. STREET ADDRESS 6910 D St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Melvenia Last Vann				4. DATE OF DEATH Month August Day 15 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				9. AGE (In years last birthday) 14 yrs.		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Vann, Michael Frederick				12. CITIZEN OF WHAT COUNTRY? USA.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME Diederick, Catherine		17. INFORMANT 6910 D St Seat Pleasant, Md	
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Diabetic COMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 HR. 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to Present , 19____, that I last saw the deceased alive on AUGUST 15 , 19 58 , and that death occurred at 10:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron G. Saidman, M.D.				ADDRESS (Street, city or town, state) 1801 - Eye St., N.W. - Washington, D.C.			
DATE SIGNED August 15, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 44 Maple Ave				ADDRESS		24a. REC'D BY REGISTRAR 19 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9421

CERTIFICATE OF DEATH

10532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl				4. DATE OF DEATH Vincent Month August Day 31 Year 19 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-58		9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) William Vincent				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Vincent				14. MOTHER'S MAIDEN NAME Yvonne Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) abnormal pulmonary ventilation (electrocardiogram) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity (1 lb 12 oz) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 25 , 19 58 , to Aug. 31 , 19 58 that I last saw the deceased alive on Aug. 31 , 19 58 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				ADDRESS (Street, city or town, state) College Park, Md		DATE SIGNED 9/2/58	
PHYSICIAN'S NAME (Type) Dr. Christensen							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/31/58		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator.				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

9422

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09448

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. LENGTH OF STAY IN 1b 47 x 3		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 1354 Montague Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Krungton Visutiphol		4. DATE OF DEATH Aug 10 1958		5. SEX male	
6. COLOR OR RACE Yellow		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1933	
9. AGE (In yrs. last birthday) 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Thailand	
12. CITIZEN OF WHAT COUNTRY? Thailand		13. FATHER'S NAME Kumton Visutiphol		14. MOTHER'S MAIDEN NAME Thonghour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address SAME Maj. Gen. M.C.J. Kritakara	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823x Hemorrhage and Shock DUE TO (b) Crushed Chest and fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) occupant of auto that ran off road and struck a telegraph pole			
20c. TIME OF INJURY Month, Day, Year 3:00 a.m. 8-10 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hillside Pk. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Aug 10, 1958	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium	
22d. LOCATION (City, town, or county) Wash. D.C.		22e. REC'D BY REGISTRAR AUG 12 1958		22f. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Decedent's Name: *James P. ...*
Age: *...*
Sex: *...*
Race: *...*
Date of Birth: *...*
Place of Birth: *...*
Usual Residence: *...*
Cause of Death: *...*
Manner of Death: *...*
Signature of Medical Examiner: *...*
Date: *...*

Signature of Medical Examiner: *...*
Date: *...*
Signature of Coroner: *...*
Date: *...*
Signature of Registrar: *...*
Date: *...*

9423

CERTIFICATE OF DEATH

09449

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Mo 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 14508 Fordham Lane	
3. NAME OF DECEASED (Type or print) First Benjamin Middle F Last Wade		4. DATE OF DEATH August 14 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Red Cross	9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months 14 Days 19 Hours 58 Min.
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin F. Wade		14. MOTHER'S MAIDEN NAME Helen Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W W I		16. SOCIAL SECURITY NO. Helen Wade Henderson	
17. INFORMANT Bethesda, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 1952 to AUG 14 1958 that I last saw the deceased alive on AUG 14 1958 and that death occurred at 10:40 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny ST DATE SIGNED 8/14/58	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		MT BAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR AUG 18 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

REG. COM. 111

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>IMMEDIATE CAUSE OF DEATH [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>TIME OF EXAMINATION [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>TIME OF SIGNATURE [Faint text]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09450**

9424

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5014 Lakeland Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michele Middle Weems Last				4. DATE OF DEATH Month August Day 5, Year 19 58			
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16-58		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months 3 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Weems				14. MOTHER'S MAIDEN NAME Delores Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-11-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington 2px	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington				ADDRESS 467 N St NW		24a. REC'D BY REGISTRAR DATE AUG 8 58	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 3 should be used as a burial-transit permit. File pages 1 and 3 with the State Board of Health. Pages 2 and 4 should be retained for your files. Pages 5 and 6 should be retained for your files. Pages 7 and 8 should be retained for your files. Pages 9 and 10 should be retained for your files. Pages 11 and 12 should be retained for your files. Pages 13 and 14 should be retained for your files. Pages 15 and 16 should be retained for your files. Pages 17 and 18 should be retained for your files. Pages 19 and 20 should be retained for your files. Pages 21 and 22 should be retained for your files. Pages 23 and 24 should be retained for your files. Pages 25 and 26 should be retained for your files. Pages 27 and 28 should be retained for your files. Pages 29 and 30 should be retained for your files. Pages 31 and 32 should be retained for your files. Pages 33 and 34 should be retained for your files. Pages 35 and 36 should be retained for your files. Pages 37 and 38 should be retained for your files. Pages 39 and 40 should be retained for your files. Pages 41 and 42 should be retained for your files. Pages 43 and 44 should be retained for your files. Pages 45 and 46 should be retained for your files. Pages 47 and 48 should be retained for your files. Pages 49 and 50 should be retained for your files. Pages 51 and 52 should be retained for your files. Pages 53 and 54 should be retained for your files. Pages 55 and 56 should be retained for your files. Pages 57 and 58 should be retained for your files. Pages 59 and 60 should be retained for your files. Pages 61 and 62 should be retained for your files. Pages 63 and 64 should be retained for your files. Pages 65 and 66 should be retained for your files. Pages 67 and 68 should be retained for your files. Pages 69 and 70 should be retained for your files. Pages 71 and 72 should be retained for your files. Pages 73 and 74 should be retained for your files. Pages 75 and 76 should be retained for your files. Pages 77 and 78 should be retained for your files. Pages 79 and 80 should be retained for your files. Pages 81 and 82 should be retained for your files. Pages 83 and 84 should be retained for your files. Pages 85 and 86 should be retained for your files. Pages 87 and 88 should be retained for your files. Pages 89 and 90 should be retained for your files. Pages 91 and 92 should be retained for your files. Pages 93 and 94 should be retained for your files. Pages 95 and 96 should be retained for your files. Pages 97 and 98 should be retained for your files. Pages 99 and 100 should be retained for your files.

9VVVVVVVXVV

FOR STATE
HEALTH DEPT.

FORM 100-10

NOT TO BE
REPRODUCED
OR
TRANSMITTED
IN ANY MANNER
WITHOUT
THE WRITTEN
CONSENT OF
THE
STATE OF
MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100

Name of Deceased Prince Georges		Sex Male		Age 1.0.A.		Date of Birth 1.0.A.	
Place of Birth Collegis Park		Usual Residence 2011 Lakeland Road		Cause of Death James A. Woods		Manner of Death James A. Woods	
Date of Death August 2, 1932		Time of Death 3-15-32		Place of Death Washington, D.C.		Physician's Name James A. Woods	
Signature of Medical Examiner John T. McJannet, M.D.		Signature of Coroner James A. Woods		Signature of Registrar James A. Woods		Signature of Burial Officer James A. Woods	
Date of Signature August 2, 1932		Date of Signature August 2, 1932		Date of Signature August 2, 1932		Date of Signature August 2, 1932	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09451

Reg. Dist. No.

9425

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. LENGTH OF STAY IN 1b <u>deceased arrived</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4420 First Place NE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Abbott</u> Last <u>White</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1926</u>	9. AGE (In years last birthday) <u>31</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign Erector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Neon Sign</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Jefferson White</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Gibbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>226-28502</u>		17. INFORMANT <u>Kenneth D Dixon, Falls Church, Va</u> Address <u>66 23 Williston Pl</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Electrocution</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was working on neon sign and shorted circuit</u>					
20c. TIME OF INJURY Month, Day, Year <u>11:50 a.m. 8/5 1958</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, or 20f. City or town) <u>Shopping Center District Heights, D.C.</u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug 5, 1958</u>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lynchburg Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Paschi Sore Hyattsville, Md</u>				24a. REC'D BY REGISTRAR <u>Aug 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G233 8/28/58 ggi

CERTIFICATE OF DEATH

9426

09452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 40 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights d. STREET ADDRESS 1013 58th Ave/ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) W. Emma		First Wilson		Middle Wilson		Last Wilson		4. DATE OF DEATH Month Aug Day 12 Year 1958	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 76 yrs.		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Frank K Newton				14. MOTHER'S MAIDEN NAME Mary Bowie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Pearl N. Gray		Address 1013 58th Ave Fairmount Heights Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertension @ F.R. Museum DUE TO (c) Unk.								INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Aug 1958 to 12 Aug 1958 , that I last saw the deceased alive on 12 Aug 1958 , and that death occurred at 11:24 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE R. J. Sasser				M.D.					
PHYSICIAN'S NAME (Type) Dr. R. Sasser									
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/16/58		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Mason				ADDRESS B. E. Thomas S. E. 2500 Nichols St		24a. REC'D BY REGISTRAR Aug 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
FACSIMILE OF DEATH

1922

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		COLOR	
CAUSE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
TIME OF DEATH		HOUR		MINUTE	
TEMPERATURE		PULSE		RESPIRATION	
BLOOD PRESSURE		WEIGHT		HEIGHT	
HAIR		EYES		MOUTH	
NOSE		EARS		TEETH	
SKIN		FINGERS		TOES	
NAILS		SCARS		TATTOOS	
TUMORS		WOUNDS		OPERATIONS	
MEDICATION		DIET		SMOKING	
ALCOHOL		DRUGS		POISON	
INFECTIONS		PARASITES		ALLERGIES	
CHRONIC DISEASES		ACUTE DISEASES		SYMPTOMS	
SIGNS		TESTS		TREATMENT	
PROGNOSIS		MORBIDITY		MORTALITY	
PREVENTION		CONTROL		RECORD	
ANALYSIS		INTERPRETATION		CONCLUSION	
REMARKS		SIGNATURE		TITLE	
DATE		PLACE		OFFICE	
STATE		COUNTY		CITY	
TOWNSHIP		WARD		BLOCK	
LOT		SECTION		RANGE	
TOWNSHIP		COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
BUREAU OF VITAL RECORDS		DEPARTMENT OF HEALTH		BALTIMORE, MARYLAND	
FACSIMILE OF DEATH		1922		1922	

CERTIFICATE OF DEATH

Reg. Dist. No.

09453

9427

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside d. STREET ADDRESS 1209 54th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma FRANCES REYNOLDS Wilson				4. DATE OF DEATH Month August Day 20 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 April 22/1893 65? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 65 yrs.	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME GEORGE PIERCE				14. MOTHER'S MAIDEN NAME MARY C ASHBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT DAVID F. WILSON Address 1209 54th AVE HILLSIDE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulm. Cong. Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertosis of internal carotid Ar. DUE TO (c) Arterio-sclerotic Hdtess. (Bilateral Medulla)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug. 19 , 19 58 , to Aug. 20 , 19 58 , that I last saw the deceased alive on Aug. 19 , 19 58 , and that death occurred at 3:50A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3308 Perry St. Mt. Rainier, Md. DATE SIGNED 8/20/58							
ACTUAL SIGNATURE C. C. Hageage				PHYSICIAN'S NAME (Type) Dr. C. Hageage., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-23-58		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 1111 1st St S.E.				24a. REC'D BY REGISTRAR DATE AUG 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. DATE OF DEATH APR 4 1968	
3. PLACE OF DEATH MEMPHIS, TENN		4. COUNTY SHELBY	
5. SEX MALE		6. AGE 35	
7. OCCUPATION ATTORNEY		8. CAUSE OF DEATH MURDER	
9. MANNER OF DEATH HOMICIDE		10. PLACE OF BURIAL MEMPHIS, TENN	
11. SIGNATURE OF PHYSICIAN JAMES EARL RAY		12. SIGNATURE OF REGISTRAR JAMES EARL RAY	
13. SIGNATURE OF WITNESS JAMES EARL RAY		14. SIGNATURE OF WITNESS JAMES EARL RAY	
15. SIGNATURE OF WITNESS JAMES EARL RAY		16. SIGNATURE OF WITNESS JAMES EARL RAY	
17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF WITNESS JAMES EARL RAY	
19. SIGNATURE OF WITNESS JAMES EARL RAY		20. SIGNATURE OF WITNESS JAMES EARL RAY	
21. SIGNATURE OF WITNESS JAMES EARL RAY		22. SIGNATURE OF WITNESS JAMES EARL RAY	
23. SIGNATURE OF WITNESS JAMES EARL RAY		24. SIGNATURE OF WITNESS JAMES EARL RAY	
25. SIGNATURE OF WITNESS JAMES EARL RAY		26. SIGNATURE OF WITNESS JAMES EARL RAY	
27. SIGNATURE OF WITNESS JAMES EARL RAY		28. SIGNATURE OF WITNESS JAMES EARL RAY	
29. SIGNATURE OF WITNESS JAMES EARL RAY		30. SIGNATURE OF WITNESS JAMES EARL RAY	
31. SIGNATURE OF WITNESS JAMES EARL RAY		32. SIGNATURE OF WITNESS JAMES EARL RAY	
33. SIGNATURE OF WITNESS JAMES EARL RAY		34. SIGNATURE OF WITNESS JAMES EARL RAY	
35. SIGNATURE OF WITNESS JAMES EARL RAY		36. SIGNATURE OF WITNESS JAMES EARL RAY	
37. SIGNATURE OF WITNESS JAMES EARL RAY		38. SIGNATURE OF WITNESS JAMES EARL RAY	
39. SIGNATURE OF WITNESS JAMES EARL RAY		40. SIGNATURE OF WITNESS JAMES EARL RAY	
41. SIGNATURE OF WITNESS JAMES EARL RAY		42. SIGNATURE OF WITNESS JAMES EARL RAY	
43. SIGNATURE OF WITNESS JAMES EARL RAY		44. SIGNATURE OF WITNESS JAMES EARL RAY	
45. SIGNATURE OF WITNESS JAMES EARL RAY		46. SIGNATURE OF WITNESS JAMES EARL RAY	
47. SIGNATURE OF WITNESS JAMES EARL RAY		48. SIGNATURE OF WITNESS JAMES EARL RAY	
49. SIGNATURE OF WITNESS JAMES EARL RAY		50. SIGNATURE OF WITNESS JAMES EARL RAY	
51. SIGNATURE OF WITNESS JAMES EARL RAY		52. SIGNATURE OF WITNESS JAMES EARL RAY	
53. SIGNATURE OF WITNESS JAMES EARL RAY		54. SIGNATURE OF WITNESS JAMES EARL RAY	
55. SIGNATURE OF WITNESS JAMES EARL RAY		56. SIGNATURE OF WITNESS JAMES EARL RAY	
57. SIGNATURE OF WITNESS JAMES EARL RAY		58. SIGNATURE OF WITNESS JAMES EARL RAY	
59. SIGNATURE OF WITNESS JAMES EARL RAY		60. SIGNATURE OF WITNESS JAMES EARL RAY	
61. SIGNATURE OF WITNESS JAMES EARL RAY		62. SIGNATURE OF WITNESS JAMES EARL RAY	
63. SIGNATURE OF WITNESS JAMES EARL RAY		64. SIGNATURE OF WITNESS JAMES EARL RAY	
65. SIGNATURE OF WITNESS JAMES EARL RAY		66. SIGNATURE OF WITNESS JAMES EARL RAY	
67. SIGNATURE OF WITNESS JAMES EARL RAY		68. SIGNATURE OF WITNESS JAMES EARL RAY	
69. SIGNATURE OF WITNESS JAMES EARL RAY		70. SIGNATURE OF WITNESS JAMES EARL RAY	
71. SIGNATURE OF WITNESS JAMES EARL RAY		72. SIGNATURE OF WITNESS JAMES EARL RAY	
73. SIGNATURE OF WITNESS JAMES EARL RAY		74. SIGNATURE OF WITNESS JAMES EARL RAY	
75. SIGNATURE OF WITNESS JAMES EARL RAY		76. SIGNATURE OF WITNESS JAMES EARL RAY	
77. SIGNATURE OF WITNESS JAMES EARL RAY		78. SIGNATURE OF WITNESS JAMES EARL RAY	
79. SIGNATURE OF WITNESS JAMES EARL RAY		80. SIGNATURE OF WITNESS JAMES EARL RAY	
81. SIGNATURE OF WITNESS JAMES EARL RAY		82. SIGNATURE OF WITNESS JAMES EARL RAY	
83. SIGNATURE OF WITNESS JAMES EARL RAY		84. SIGNATURE OF WITNESS JAMES EARL RAY	
85. SIGNATURE OF WITNESS JAMES EARL RAY		86. SIGNATURE OF WITNESS JAMES EARL RAY	
87. SIGNATURE OF WITNESS JAMES EARL RAY		88. SIGNATURE OF WITNESS JAMES EARL RAY	
89. SIGNATURE OF WITNESS JAMES EARL RAY		90. SIGNATURE OF WITNESS JAMES EARL RAY	
91. SIGNATURE OF WITNESS JAMES EARL RAY		92. SIGNATURE OF WITNESS JAMES EARL RAY	
93. SIGNATURE OF WITNESS JAMES EARL RAY		94. SIGNATURE OF WITNESS JAMES EARL RAY	
95. SIGNATURE OF WITNESS JAMES EARL RAY		96. SIGNATURE OF WITNESS JAMES EARL RAY	
97. SIGNATURE OF WITNESS JAMES EARL RAY		98. SIGNATURE OF WITNESS JAMES EARL RAY	
99. SIGNATURE OF WITNESS JAMES EARL RAY		100. SIGNATURE OF WITNESS JAMES EARL RAY	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09454

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D.O.A..	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Arlington Barracks, Quarters K.	
3. NAME OF DECEASED (Type or print) Clarence Nelson Wright, Jr.		4. DATE OF DEATH August 2, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6-7-37
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Clarence Nelson Wright		14. MOTHER'S MAIDEN NAME Ula Mae	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Currently		16. SOCIAL SECURITY NO. 425-64-8423	
17. INFORMANT Dept. of the Navy, Lt. Fred Wehring.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning (c) Automobile accident		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile which went out of control and landed upside down in a creek. Subject removed from two feet of water.	
20c. TIME OF INJURY Month, Day, Year 12-15 8-2-58 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, etc.) Creek		20f. (City or town) E. Riverdale, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 2, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR		22b. DATE THEREOF 8-4-1958	
22c. NAME OF CEMETERY OR CREMATORY NEWTON		22d. LOCATION (City, town, or county) (State) MISS	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, CO.		ADDRESS 1400 CHAPIN ST NW	
24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE Alfred	

